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# **Overcoming Isolation: Faith and Social Support in Severe and Enduring Mental Illness**

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This thesis is submitted in partial fulfilment of the requirements for the degree of  
Doctorate in Clinical Psychology.

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## **Declaration**

The research reported in this thesis was conducted under the supervision of Dr Adrian Neal (Clinical Psychologist, NHS), Jo Kucharska (Clinical Psychologist, Coventry University) and Deborah Biggerstaff (Chartered Psychologist in Health, Warwick University). Supervisors provided advice throughout the research process and gave feedback on draft versions of this thesis. Apart from this supervisory contribution the material presented in this thesis represents original work carried out by myself.

This thesis has not been submitted for a degree at any other university.

Supervisors will be acknowledged as co-authors in any publications arising from this thesis.

## Summary

This thesis presents three papers united by a common focus on the experiences of individuals with severe and enduring mental illness (SEMI).

Chapter 1 presents a systematic review exploring befriending interventions for individuals with SEMI. Database searches identified 20 relevant studies; seven studies of volunteer befriending (VBF) and thirteen studies which used befriending control therapy (BCT) in trials of Cognitive Behavioural Therapy (CBT). These studies were limited by methodological problems, particularly oversampling. Initial findings indicate that VBF provides increased social support but has little effect on clinical outcomes. When successful, VBF may provide increasing benefits over time. Studies investigating BCT found that it often performed comparably to CBT, indicating that BCT represents an active therapy rather than a control condition. These findings suggest that social support can have considerable benefits for individuals with SEMI.

Chapter 2 presents an empirical study examining the experience of Christians diagnosed with psychosis. Semi-structured interviews with eight participants were analysed using Interpretative Phenomenological Analysis, producing two superordinate themes. The first theme describes participants' struggle to find meaning and certainty amidst the confusion of psychotic illness. Participants described faith as both exacerbating and alleviating this confusion. The second theme describes participants' search for acceptance from others. Participants described encountering unhelpful attitudes held by mental health professionals (MHPs) and other Christians, leaving them feeling devalued. By contrast, when professionals and Christians were accepting and supportive participants described feeling more fully human. This study highlights the importance of MHPs considering patients' spiritual needs and suggests that Christians with psychosis may be a significantly marginalised and misunderstood group.

Chapter 3 presents a reflective account of the researcher's experiences in conducting the empirical study presented in Chapter 2. The focus of this paper is on the researcher's experience of managing the roles of Psychologist, Researcher and Christian.

## **List of Abbreviations**

<b>ACE</b>	Active Cognitive Therapy for Early Psychosis
<b>ACT</b>	Acceptance and Commitment Therapy
<b>BCT</b>	Befriending Control Therapy
<b>CASP</b>	Critical Appraisal Skills Programme
<b>CH</b>	Command Hallucination
<b>CP</b>	Clinical Psychologist
<b>CBT</b>	Cognitive Behavioural Therapy
<b>CINAHL</b>	Cumulative Index to Nursing and Allied Health
<b>CPRS</b>	Comprehensive Psychiatric Rating Scale
<b>EBSCO</b>	EBSCO Information Services (article search database)
<b>EMBASE</b>	Excerpta Medica dataBASE (article search database)
<b>FEP</b>	First Episode Psychosis
<b>F/U</b>	Follow-up
<b>IPA</b>	Interpretative Phenomenological Analysis
<b>LN</b>	London-Newcastle (study)
<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>OCD</b>	Obsessive-Compulsive Disorder
<b>PTSD</b>	Post-Traumatic Stress Disorder

<b>QoL</b>	Quality of Life
<b>RCT</b>	Randomised Control Trial
<b>SEMI</b>	Severe and Enduring Mental Illness
<b>SMI</b>	'Severe' or 'Serious' Mental Illness
<b>SU</b>	Service User
<b>TORCH</b>	Treatment Of Resistant Command Hallucinations
<b>VBF</b>	Volunteer Befriending

## **Chapter 1: Literature Review Paper**

### **A Systematic Review of Befriending Interventions for Individuals with Severe and Enduring Mental Illness**

**Target Journal:** *Clinical Psychology Review*

Page Count\*: 50 pages.

(Word Count, excluding tables, figures, and reference list: 8687).

\*See Appendix A for Submission Guidelines.

## **1.1 Abstract**

Individuals with Severe and Enduring Mental Illness (SEMI) are often socially isolated and may lack social skills. In addressing these problems psychosocial interventions may be beneficial. Befriending is a widely used psychosocial intervention providing supportive social contact. One previous review found that befriending reduces symptoms of depression and distress, however no reviews have yet examined befriending in the SEMI population. This paper systematically reviews studies investigating befriending as an intervention for SEMI.

Seven databases were searched, identifying twenty studies. Seven studies investigated volunteer befriending (VBF) and thirteen studies used befriending control therapy (BCT) in trials of Cognitive Behavioural Therapy (CBT). Studies suffered from various methodological limitations including limited power and oversampling. Overall more original research is needed in this area.

Although limited, current evidence suggests that VBF provides increased social support but has little effect on clinical outcomes. However studies may underestimate the benefits of VBF, which appear greater in successful befriending matches. Future studies of VBF should evaluate longer interventions and use more naturalistic designs. Studies investigating BCT found that it performed comparably to CBT, although CBT often produced larger or more durable effects. These findings indicate that BCT represents an active therapy providing unstructured social support.



**Keywords:** *Befriending; Severe Mental Illness; Cognitive Behavioral Therapy; Systematic Review.*

## **1.2. Introduction**

### **1.2.1 Definitions and Terminology**

There is a lack of consistency in definitions of Severe and Enduring Mental Illness (SEMI) (Parabiaghi, Bonetto, Ruggeri, Lasalvia, & Leese, 2006; Ruggeri, Leese, Thornicroft, Bisoffi, & Tansella, 2000). This is reflected in the use of various terms for this client group, including ‘Severe Mental Illness’, ‘Serious Mental Illness’ and ‘Severe and Persistent Mental Illness’. Definitions of SEMI consistently include psychotic disorders such as schizophrenia and bipolar disorder, but may also include personality disorders, severe anxiety disorders, severe eating disorders and major depression (e.g. Department of Health, 1999; Sainsbury Centre for Mental Health, 1998). Parabiaghi et al. (2006) found that combining measures of functional impairment and illness duration was more effective in predicting continued SEMI than diagnosis.

In providing guidance for Clinical Psychologists working with clients who experience SEMI the Division of Clinical Psychologists (British Psychological Society, 2002) used the National Service Framework definition of SEMI:

*“people with recurrent or severe and enduring mental illness... who have complex needs which require the continuing care of specialist mental health*

*services working effectively with other agencies.”* (Department of Health, 1999, p. 3).

For the purposes of this review the term SEMI has been chosen as it encompasses all other terms, incorporating both functional and diagnostic definitions.

### **1.2.2 Impact of SEMI**

Given the variability in definitions of SEMI, estimates of its prevalence and impact are inconsistent. One report which aggregated available figures estimated prevalence rates of 2-4% for severe mental illness and 0.3-1.5% for SEMI (Sainsbury Centre for Mental Health, 1998). However, although SEMI affects a small proportion of the population, the consequences for sufferers are severe in terms of life outcomes and wellbeing. In addition to experiencing chronic distressing symptoms of mental illness, these individuals often have deficits in social functioning, which are compounded by social stigma (Sainsbury Centre for Mental Health, 1998). Consequently they are more likely to experience loneliness than the general population (Perese & Wolf, 2005). Outcomes for those with schizophrenia are particularly negative with very low rates of employment, increased risk of suicide and higher rates of mortality than the general population (NICE, 2014).

In addition to these significant costs to the individual, the cost of SEMI to society is also considerable. In England alone in 2011/12 schizophrenia was estimated to cost £2.4 billion in treatment and care costs and £5.6 billion in indirect costs to society, amounting to £65,000 annually per person with schizophrenia (NICE, 2014).

### **1.2.3 Treatment for SEMI**

For individuals with psychosis and schizophrenia the main form of treatment remains antipsychotic medication. While the efficacy of such medications is well established a considerable proportion of patients with psychosis and schizophrenia continue to experience psychotic symptoms (Newton-Howes & Wood, 2013; NICE, 2014). Psychological or psychosocial interventions are particularly used as an alternative or adjunctive treatment for medication-resistant patients. Besides symptom reduction, such interventions may be able to target the loneliness and social impairments experienced by patients with SEMI (NICE, 2014; Perese & Wolf, 2005).

Cognitive Behavioural Therapy (CBT) is now established as an effective treatment for schizophrenia, producing moderate effect sizes (Draper, Velligan, & Tai, 2010). It is also effective for medication-resistant schizophrenia (Rathod, Kingdon, Weiden, & Turkington, 2008). However CBT may not be the only effective psychosocial intervention for schizophrenia. Two recent meta-analyses found that CBT was no more effective than supportive therapy or other similar interventions for patients with schizophrenia (Jones, Hacker, Cormac, Meaden, & Irving, 2012; Newton-Howes & Wood, 2013). Consequently Newton-Howes and Wood (2013) have suggested that simpler supportive therapies should be considered for patients with psychotic disorders as they may be more accessible for this population than more complex CBT interventions.

Supportive interventions may represent a more cost-effective treatment option with lower training and delivery costs than CBT. Such interventions could also provide greater patient choice for individuals with SEMI.

#### **1.2.4 Psychosocial Interventions for SEMI**

Several reviews have considered the provision of psychosocial interventions for people with SEMI (Davidson et al., 1999; Hallett, Klug, Lauber, & Priebe, 2012; Perese & Wolf, 2005). The quality and quantity of studies considered by these reviews has generally been limited, however existing evidence indicates that psychosocial interventions are beneficial for individuals with SEMI. Such interventions include support groups, psychosocial clubs, mutual help groups, peer support services and the provision of volunteers such as befrienders.

#### **1.2.5 Befriending**

One psychosocial intervention which may be particularly suited to reducing loneliness and social isolation for individuals experiencing SEMI is befriending. Dean and Goodlad (1998, p. 2) define befriending as:

*“a relationship between two or more individuals which is initiated, supported, and monitored by an agency that has defined one or more parties as likely to benefit. Ideally the relationship is non-judgemental, mutual, purposeful, and there is a commitment over time.”*

In providing supported companionship befriending directly targets social isolation. Befriending may facilitate greater social integration by providing individuals with opportunities to engage in social activities in the community. Given that befriending is typically delivered by volunteers (Dean & Goodlad, 1998) it may be a cost-effective treatment option.

Befriending is already a well-established intervention. Dean and Goodlad (1998) surveyed 234 organisations offering befriending in the UK, although this number is likely to have grown. Indeed 3000 registered mentoring or befriending services are reported in the UK at present (Mentoring and Befriending Foundation, 2014) although it is unclear what proportion of these services offer befriending. Groups targeted by befriending schemes include individuals with mental health problems; older people and their carers; people with disabilities and chronic illnesses; individuals with autism or other learning disabilities and vulnerable young people, such as looked-after children and care-leavers (Dean & Goodlad, 1998; Mentoring and Befriending Foundation, 2010).

#### **1.2.6 Impact of Befriending**

Despite the wide range of befriending schemes in operation, existing evidence of the impact of befriending on non-psychiatric client groups is limited. Although several reviews have investigated befriending in such groups (Dean & Goodlad, 1998; Kersley, Estep, & Leadley, 2014; Mentoring and Befriending Foundation, 2010; Phillip & Spratt, 2007), none have been systematic in nature. Likewise

individual studies have typically been qualitative and small-scale, with few conducting formal evaluation with outcome measures. Nevertheless the qualitative evidence provided by these studies and reviews predominantly indicates that recipients are appreciative of befriending and consider it beneficial. Reported benefits include gaining a friendship independent of services, increased perceived social support and greater community engagement. However not all studies reported positive outcomes; a study of befriending for dementia carers found that uptake of befriending was low and carers did not experience improvement in wellbeing or quality of life (Charlesworth et al., 2008), suggesting befriending was less suitable for this group.

For individuals with mental health difficulties there is stronger evidence for the effectiveness of befriending. Mead, Lester, Chew-Graham, Gask, and Bower (2010) conducted a meta-analysis of 24 randomised controlled trials (RCTs) investigating the impact of befriending on depression and distress. They found modest but significant short- and long-term effects for befriending compared with treatment as usual. This review included three studies of befriending for individuals with SEMI.

### **1.2.7 Befriending for SEMI**

To date no literature reviews have exclusively focused on befriending for SEMI. Perese and Wolf (2005) considered befriending alongside several social network interventions for SEMI. However this was not a systematic review and its coverage of befriending was very limited. Likewise befriending accounted for only seven of

fourteen studies in a systematic review of volunteering interventions for SEMI (Hallett et al., 2012).

Despite the absence of reviews examining befriending for SEMI, clinical guidance has recommended befriending for individuals with SEMI conditions. Current NICE guidelines recommend befriending for individuals with severe chronic depression and bipolar disorder (NICE, 2006, 2010). These recommendations, however, are based upon limited evidence provided by a single moderately-sized study of women with chronic depression.

#### **1.2.8 Summary**

Befriending is a widely used intervention which appears to be acceptable and beneficial for a range of client groups and has been shown to provide some benefit in reducing symptoms of depression and distress. However it has yet to be evaluated for individuals with SEMI, who differ considerably from other service user groups. Given that befriending provides social support it may be particularly beneficial for individuals with SEMI who often experience severe social isolation and may lack social skills. For such individuals befriending may offer a cost-effective alternative or adjunctive treatment. In response to these speculations and in the absence of any previous reviews, this paper will synthesise existing research investigating befriending in the SEMI population.

### 1.2.9 Review Aims

The aim of this paper is to systematically review studies of befriending as an intervention for SEMI. In the absence of previous reviews of this subject this is an exploratory review. It is hoped that this review will identify any clinical and social benefits of befriending for individuals with SEMI.

## 1.3 Methodology

### 1.3.1 Search Strategy

Systematic searches were conducted using electronic databases selected to achieve breadth of coverage encompassing psychiatry, psychology, nursing and other social care fields. In total seven databases were searched (**Table 1.1**).

Provider	Databases searched
Proquest	<ul style="list-style-type: none"><li>• Applied Social Science Index and Abstracts (ASSIA),</li><li>• International Bibliography of the Social Sciences (IBSS)</li><li>• PsychINFO</li><li>• PsychARTICLES</li></ul>
OVID	<ul style="list-style-type: none"><li>• Medline</li><li>• EMBASE</li></ul>
EBSCO	<ul style="list-style-type: none"><li>• Cumulative Index to Nursing and Allied Health (CINAHL)</li></ul>

*Table 1.1: Databases searched.*



### **1.3.2 Inclusion and Exclusion Criteria**

Studies were included if they evaluated an intervention primarily involving the provision of unstructured social-support, delivered face-to-face to individuals and identified as 'befriending.' Befriending could be delivered either by professionals or volunteers and could either be a primary intervention or a control condition.

Studies using an intervention not labelled 'befriending' were included only if the intervention was not judged to diverge from the above criteria and providing that the intervention was based on another pre-existing intervention which identified itself as 'befriending'. For example 'supported socialization' is not typically identified as befriending but is based upon the 'Compeer' model of befriending (e.g. McCorkle, Dunn, Wan, & Gagne, 2009). Where a study used data from the same sample as a previous study it was only included if it contributed to the evidence base by assessing different outcomes or providing follow-up data.

In light of the exploratory nature of this review, the relative paucity of research in this area and the ongoing controversy surrounding the validity of diagnostic terms such as schizophrenia (Bentall, 2009), a broad definition of SEMI was adopted, incorporating both diagnostic and functional criteria. Thus studies were included if participants were diagnosed with a psychotic disorder (including First Episode Psychosis) or alternatively if participants had a chronic mental health problem with a high level of severity as judged by qualified clinicians or indicated by significant functional impairment. Studies that recruited mixed samples, incorporating participants with mild mental health problems were excluded. Books, conference

proceedings, commentary articles, purely descriptive studies and studies written in languages other than English were also excluded.

### 1.3.3 Search Record

The stages of the search process are described in **Table 1.2**. Stages four to six are reported in full in **section 1.3.4**.

Search Phase	Strategy	Notes
<b>1</b>	Initial searches made for articles returning “befriending” and “psychosis” as keywords.	Few relevant results obtained.
<b>2</b>	Searches extended to combinations of “befriending” and other psychotic disorders (e.g. schizophrenia, bipolar disorder).	Few results obtained. Decision to broaden review focus to examine all diagnoses within SEMI.
<b>3</b>	Searches for combinations of “befriending” and SEMI diagnostic categories (e.g. ‘schizophrenia’, ‘first episode psychosis’, ‘severe mental illness’).	Few results in which befriending was a primary intervention. Search extended to identify studies not using diagnostic categories or using terms other than ‘befriending’.
<b>4</b>	Searches using only “befriending” as title or keyword.	Several additional relevant studies identified. Also enabled identification of all previously identified studies.
<b>5</b>	Primary and Secondary reference list searches.	
<b>6</b>	Citation searches.	

*Table 1.2: Stages of the search process.*

### 1.3.4 Search Results and Study Selection

Fourth phase searches were conducted using all seven databases on 8<sup>th</sup> March 2014. These searches produced 365 records, 166 of which were excluded as duplicates. The remaining 199 records were screened by title. Abstracts were also screened if the title indicated possible relevance. This resulted in 160 further exclusions. 39 full-text articles were screened. This resulted in 23 further exclusions: 15 articles which described or discussed befriending services without formal evaluation, three articles with samples not meeting the criteria for SEMI, three descriptive conference proceedings and two articles summarising or re-reporting studies reported more fully in another article.

Reference list searches were then conducted for all studies in which befriending was a primary intervention. Four further articles were full-text screened, of which two purely descriptive articles were excluded. Secondary reference-list searching identified three further studies, two of which were excluded due to being book chapters. Finally citation searches were conducted using Proquest, Web of Science and Google Scholar for studies in which befriending was not a control condition, producing one further article which met eligibility criteria. In total 20 articles suitable for inclusion were identified. This process is illustrated in **Figure 1.1**, below.

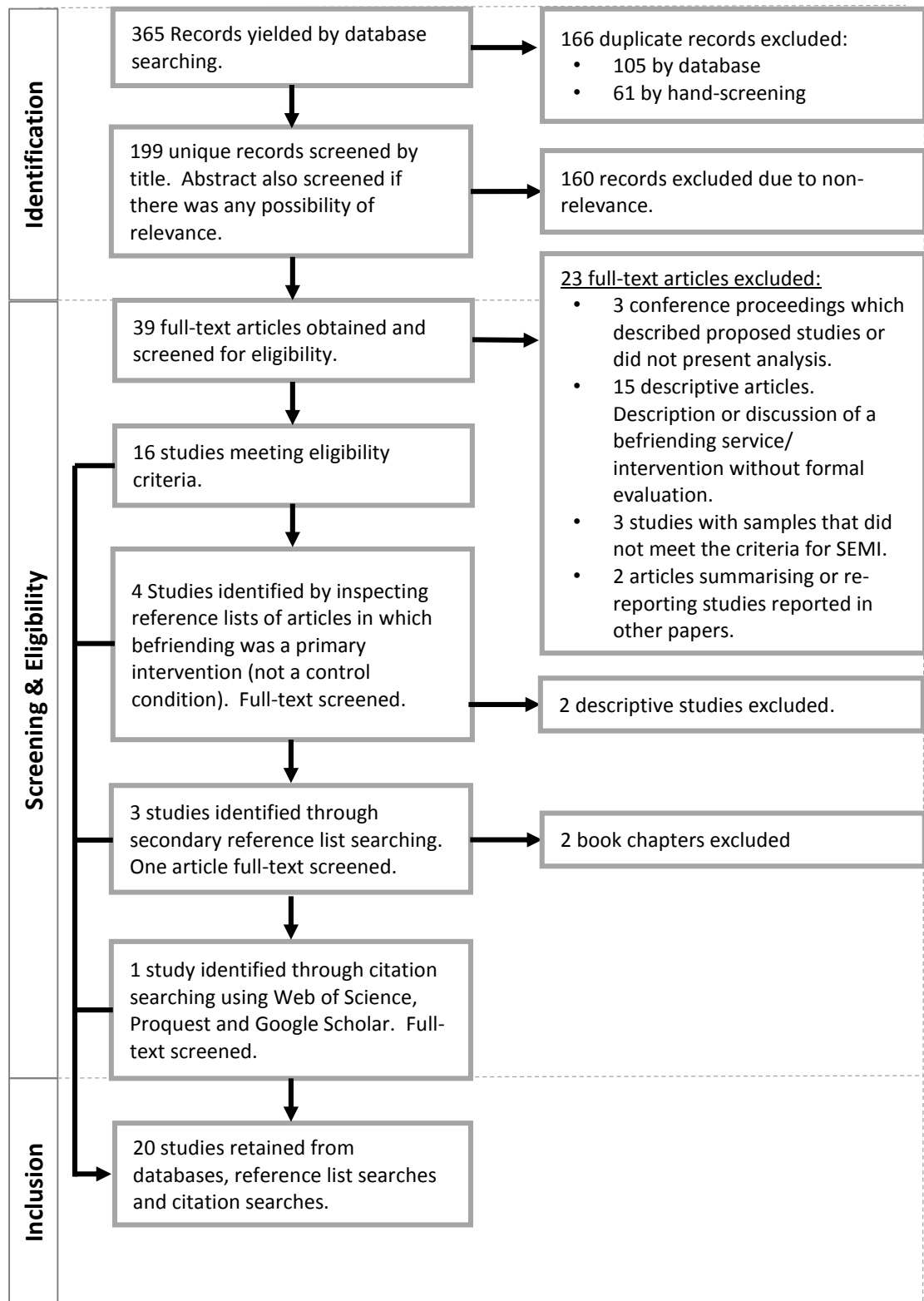


Figure 1.1 PRISMA diagram illustrating study selection process.

### 1.3.5 Quality Assessment

The 20 studies reviewed are summarised in **Appendix B**, with intervention details shown in **Appendix C**. The quality of evidence provided by these studies was assessed using a 19-item framework (**Appendix D**) adapted from Caldwell, Henshaw, and Taylor (2011), with additions drawn from the CASP Tools (CASP, 2013) and Greenhalgh (2010). This framework was selected as it is thorough and gives equal weight to quantitative and qualitative studies.

Items in this framework were weighted according to their potential to indicate issues of bias, reliability or validity and thus threaten the generalisability of findings. On each item of the framework studies were given a numeric rating in accordance with the item weighting and a descriptive rating of 'good', 'fair', 'poor' or 'none' (alternatively: 'yes', 'partially' or 'no', as appropriate). The weighted scores were used to produce a percentage score of overall study quality. Studies scoring above 80% and 60% were considered good and fair in quality respectively. Studies scoring below 60% were considered poor in quality. Studies ranged widely in quality rating from 49% to 92% with an average score of 74%. Six studies were of good quality, ten were of fair quality and four were of poor quality. Quality ratings are shown in **Tables 1.3** and **1.4**, below. Due to the paucity of research in this area and the exploratory nature of this review no threshold of study quality was set for inclusion in the review. Instead quality ratings were used to identify the strength of evidence when reviewing study findings.

Measure:	Study Weighting of Measure →	1) Allott et al. 2011	2) Bateman et al. 2007	3) Bendall et al. 2006	4) Bendall et al. 2013	5) Davidson et al. 2004	6) De Paiva Barretto et al. 2009	7) Harris et al. 1999a	8) Harris et al. 1999b	9) Jackson et al. 2008	10) McCorkle et al. 2008	11) Milne et al. 2006	12) Naeem et al. 2006	13) Samarasekera et al. 2007	14) Sensky et al. 2000	15) Shawyer et al. 2012	16) Turkington & Kingdon 2000	17) Turkington et al. 2008
1) Author credibility?	1	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2) Literature review comprehensive?	2	Good	Good	Good	Good	Fair	Poor	Poor	Fair	Good	Good	Good	Good	Good	Good	Good	Good	Fair
3) Research rationale outlined?	3	Good	Fair	Good	Good	Poor	Good	Good	Good	Good	Good	Fair	Good	Good	Good	Good	Fair	Fair
4) Research aim stated?	2	Good	Fair	Good	Good	Good	Good	Good	Good	Good	Good	Fair	Good	Good	Good	Good	Poor	Poor
5) Ethical issues identified, addressed?	3	Good	Fair	Good	Good	None	Good	None	None	Good	Poor	Poor	Fair	Poor	Fair	Fair	Good	Fair
6) Methodology identified & justified?	4	Good	Fair	Good	Good	Poor	Fair	Fair	Good	Good	Good	Good	Good	Good	Good	Fair	Fair	Good
7) All interventions clearly described?	4	Good	Fair	Good	Good	Good	Poor	Good	Good	Good	Good	Good	Good	Good	Fair	Good	Good	Good
8) Study design stated & rationale given?	5	Good	Good	Good	Good	Fair	Good	Fair	Good	Good	Good	Fair	Good	Good	Good	Fair	Fair	Good
9) Hypothesis & variables outlined?	4	Good	Fair	Good	Good	Good	Good	Good	Fair	Good	Fair	Good	Good	Good	Good	Good	Good	Fair
10) Population identified?	3	Good	Fair	Good	Good	Good	Poor	Good	Good	Good	Good	Fair	Fair	Fair	Fair	Good	Poor	Fair
11) Sample described & representative?	5	Fair	Good	Fair	Fair	Good	Poor	Good	Good	Fair	Fair	Poor	Good	Fair	Good	Good	Poor	Good

Table 1.3: Quality assessment ratings of quantitative studies (continued overleaf).

(Continued)	Measure:	17) Turkington et al. 2008	16) Turkington & Kingdon 2000	15) Shawyer et al. 2012	14) Sensky et al. 2000	13) Samarasekera et al. 2007	12) Naeem et al. 2006	11) Milne et al. 2006	10) McCorkle et al. 2008	9) Jackson et al. 2008	8) Harris et al. 1999b	7) Harris et al. 1999a	6) De Paiva Barretto et al. 2009	5) Davidson et al. 2004	4) Bendall et al. 2013	3) Bendall et al. 2006	2) Bateman et al. 2007	1) Allott et al. 2011	↕ Study Weighting of Measure →
12) Sufficient power and duration?	5	Good	Poor	Poor	Good	Fair	Good	Poor	Good	Good	Good	Fair	Poor	Fair	Good	Poor	Good	Poor	5
13) Biases controlled?	5	Good	Fair	Fair	Good	Good	Good	Poor	Fair	Good	Good	Good	Poor	Good	Good	Fair	Good	Good	5
14) Data collection valid & reliable?	4	Good	Good	Good	Good	Good	Good	Good	Poor	Good	Good	Poor	Good	Fair	Good	Poor	Fair	Good	4
15) Data analysis valid & reliable?	4	Good	Poor	Good	Good	Good	Good	Good	Good	Good	Good	Fair	Fair	Poor	Good	Good	Good	Good	4
16) Results clearly presented?	3	Good	Good	Good	Good	Fair	Fair	Good	Good	Fair	Good	Poor	Poor	Poor	Good	Good	Good	Good	3
17) Discussion comprehensive?	3	Good	Poor	Good	Good	Fair	Fair	Poor	Fair	Good	Fair	Good	Poor	Poor	Good	Good	Good	Good	3
18) Generalisability?	3	Fair	Poor	Fair	Good	Fair	Good	Poor	Fair	Good	Good	Fair	Poor	Poor	Fair	Fair	Fair	Fair	3
19) Conclusions reasonable & comprehensive?	2	Good	Fair	Good	Good	Fair	Fair	Fair	Good	Good	Fair	Good	Poor	Poor	Good	Good	Good	Good	2
Total score (/65)		50	37	50	57	51	55	40	49	56	51	43	32	38	40	52	49	56	
Study quality rating (%)		77	57	77	88	78	85	62	75	86	78	66	49	58	92	80	75	86	
Study quality descriptor		Fair	Poor	Fair	Good	Fair	Good	Fair	Fair	Good	Fair	Fair	Poor	Poor	Good	Good	Fair	Good	

Table 1.3: Quality assessment ratings of quantitative studies (continued).

Measure:	Study: ↑ Weighting of Measure →	1) Bradshaw & Haddock 1998	2) Davidson et al. 2001	3) McCorkle et al. 2009
1) Author credibility?	1	Yes	Yes	Yes
2) Literature review comprehensive?	2	Good	Fair	Good
3) Research rationale outlined?	3	Good	Fair	Good
4) Research aim stated?	2	Good	Fair	Good
5) Ethical issues identified, addressed?	3	Good	Poor	Fair
6) Methodology identified & justified?	4	Poor	Good	Good
7) All interventions clearly described?	4	Poor	Good	Good
8) Design identified and rationale outlined?	5	Poor	Good	Fair
9) Concepts identified & appropriate?	4	Good	Good	Good
10) Study context outlined?	3	Fair	Fair	Fair
11) Sampling method described & justified?	5	Fair	Fair	Fair
12) Saturation / sufficiency reached?	5	Fair	Fair	Good
13) Consideration of researcher's position?	5	No	No	No
14) Data collection appropriate & auditable?	4	Fair	Good	Good
15) Data analysis credible & confirmable?	4	Poor	Good	Good
16) Results clearly presented?	3	Good	Fair	Good
17) Discussion comprehensive?	3	Fair	Fair	Good
18) Results transferable?	3	Fair	Fair	Fair
19) Conclusions reasonable & comprehensive?	2	Fair	Good	Good
Total score (/65)		37	44	50
Study quality rating (%)		<b>57</b>	<b>68</b>	<b>77</b>
Study quality descriptor		<b>Poor</b>	<b>Fair</b>	<b>Fair</b>

Table 1.4: Quality assessment ratings of qualitative and mixed method studies.



## **1.4 Analysis**

The studies in this review fell into two broad categories: studies evaluating volunteer befriending programmes and trials of CBT using befriending as a control therapy. The purpose, format and delivery of these interventions was sufficiently dissimilar to consider the types of befriending interventions in these two groups of studies as qualitatively different and therefore the analysis below will consider these two types of study separately. The first section considers the experience of volunteer befriending and the effectiveness of such programmes, while the second section considers the comparative effectiveness of befriending in relation to CBT therapies and how appropriate befriending is as a control condition in trials of CBT.

### **1.4.1 Studies Investigating Volunteer Befriending**

#### ***1.4.1.1 Overview of Studies***

Seven studies investigated volunteer befriending as a primary intervention, although two used sub-samples of other studies from this section of the review, resulting in only five completely distinct samples.

All studies matched clients with volunteers who typically met with them weekly on average. The duration of meetings ranged from one to four hours per week, with considerable variation both between studies and within samples. In all studies participants were encouraged to meet in the community to engage in social activities, although in three studies meetings often, or primarily, took place in

clients' homes (Bradshaw & Haddock, 1998; Harris, Brown, & Robinson, 1999a, 1999b). The length of intervention at the time of interview or final measurement ranged from an average of one to three months (Bradshaw & Haddock, 1998) to nine months (Davidson et al., 2001; Davidson et al., 2004), 12 months (Harris et al., 1999a, 1999b; McCorkle, Rogers, Dunn, Lyass, & Wan, 2008) and an average of one to two years (McCorkle et al., 2009).

Five studies evaluated schemes identified as befriending, including two using the Compeer model (McCorkle et al., 2009; McCorkle et al., 2008). Two studies evaluated Supported Socialization interventions, based on the Compeer model but providing participants and volunteers a monthly stipend of \$28 to fund their activities (Davidson et al., 2001; Davidson et al., 2004). The four Supported Socialization and Compeer studies were the only ones to compare the use of Service User (SU) volunteers and non-SU volunteers.

#### ***1.4.1.2 Satisfaction and Acceptability***

Across all four studies that investigated participants' opinions of befriending services, participants consistently rated the interventions positively (Bradshaw & Haddock, 1998; Davidson et al., 2001; Davidson et al., 2004; McCorkle et al., 2009). Bradshaw and Haddock (1998) interviewed clients involved in a befriending scheme run by a local charity and reported that all nine participants rated befriending as a valuable service which had been helpful to them. Likewise in a qualitative study which interviewed 20 clients and volunteers involved in ongoing Compeer

befriending matches, feedback from both groups regarding the befriending intervention was overwhelmingly positive (McCorkle et al., 2009). Similarly, in another qualitative study of 21 clients completing nine months of Supported Socialization (Davidson et al., 2001) feedback about the service was again consistently positive. However bias may have affected this finding as six clients declined to be interviewed and the interviewers appear to have administered the intervention.

The largest and only quantitative study to investigate satisfaction was an RCT with 260 participants (Davidson et al., 2004) in which clients were given a \$28 monthly stipend and matched with an SU volunteer, matched with a non-SU volunteer or allocated to the control condition. In this study participants in all conditions reported positive levels of satisfaction at baseline, mid-way and the endpoint of the intervention, including participants in the control condition, who were not matched with a volunteer but still received the \$28 monthly stipend. It is therefore possible that the positive ratings in this study may reflect satisfaction with financial assistance rather than the experience of befriending. Interestingly Davidson et al. (2004) found that participants matched with SU volunteers were significantly less satisfied with the intervention if they met with their volunteers regularly than those matched with non-SU volunteers. However, this result was produced in one of many post-hoc tests which appear not to have been adjusted for type-1 error and such adjustment could have rendered it non-significant.

#### ***1.4.1.3 Experiences of befriending.***

The two qualitative studies (Davidson et al., 2001; McCorkle et al., 2009) and one mixed method study (Bradshaw & Haddock, 1998) that investigated the acceptability of befriending also investigated the experience of befriending for participants. The two qualitative studies analysed participants' experiences of befriending using phenomenology (Davidson et al., 2001) and grounded theory techniques (McCorkle et al., 2009).

In all three of these studies clients described a range of benefits resulting from befriending. Clients consistently described getting out and trying new activities, with associated improvements in social confidence. A further recurrent theme was of the benefits of companionship and friendship. Bradshaw and Haddock (1998) noted that for clients living alone befriending was often used for companionship, whereas for clients living with carers befriending was used to get out and access activities in the community. However this distinction was not reported in the two qualitative studies and may reflect the brief duration of matches at the time of interview, which was typically 1-3 months. By contrast the primary themes emerging in the other two studies centred around friendships developing over time to become close, trusting, genuine and reciprocal. In both studies the developing friendship was described as producing various personal benefits, including reductions in felt stigma and improved self-esteem. For McCorkle et al. (2009) the most profound changes seemed to occur after the first year, beyond the scope of the other studies, leading them to suggest that friendship should be considered the active ingredient of befriending and may take several years to fully develop.

In both qualitative studies (Davidson et al., 2001; McCorkle et al., 2009) SU volunteers were seen as inspiring by clients and in the latter they were seen as more sensitive to clients' experiences and more likely to act as advocates for their clients. However Davidson et al. (2001) note that clients seemed equally glad with both SU and non-SU volunteers for different reasons, seeing non-SU volunteers as providing opportunities to escape the 'world of mental health.'

In all three studies the drawbacks of befriending expressed by clients were not consistent, although there were repeated themes relating to the disparity between the status and lifestyles of volunteers compared to those of clients.

Volunteers interviewed by McCorkle et al. (2009) described similar benefits of befriending to those expressed by clients, primarily focussing on gaining close, reciprocal friendship. When asked about drawbacks, volunteers most often referred to the time commitment and problems early in the relationship relating to boundaries, such as feeling 'treated as a taxicab'.

While these studies provide rich descriptive data, each had methodological limitations. Firstly Bradshaw and Haddock (1998) used opportunity sampling and provide only a limited report of themes rather than undertaking formal thematic analysis. Davidson et al. (2001) appear not to have asked participants about negative aspects of their experience and, as already noted, their sample is likely to have been biased. Likewise, despite using theoretical sampling to achieve representativeness, McCorkle et al. (2009) recognise that their sample was biased as they selected to interview clients and volunteers from successful befriending matches. Therefore the experiences reported here perhaps best represent the

potential of successful befriending relationships and may be relatively unrepresentative of befriending in general.

#### ***1.4.1.4 Effectiveness of Befriending***

Three studies investigated the effectiveness of befriending in causing change on a range of clinical and functional outcomes (Davidson et al., 2004; Harris et al., 1999a, 1999b; McCorkle et al., 2008). These studies comprised one moderately-sized (N=154) quasi-experimental study with a matched-control design (McCorkle et al., 2008) and two RCTs: one moderately-sized (N=86) unblinded trial (Harris et al., 1999a, 1999b) and one large (N=260) single-blinded trial (Davidson et al., 2004).

##### ***1.4.1.4.1 Clinical Outcomes***

##### ***Psychiatric Symptoms***

Two studies investigated the effect of befriending on general psychiatric symptoms (Davidson et al., 2004; McCorkle et al., 2008), however neither study found significant differences between the befriending and control groups. McCorkle et al. (2008) report significant reductions in psychiatric symptoms for 'treatment responders' in the befriending group between baseline and completion, although no comparison was made between this group and controls. However Davidson et al. (2004) found significant reductions in psychiatric symptoms between baseline, midpoint and completion in all groups, including controls, suggesting that

befriending is no more effective than the provision of a monthly stipend for social activities.

### Depression

Similarly Davidson et al. (2004) found no significant group differences in levels of depression between intervention and control groups. However an unblinded RCT of befriending for women with chronic major depression (Harris et al., 1999a) found that participants experienced full or partial remission in depressive symptoms significantly more often when allocated to befriending than in a control condition (65% vs. 39% respectively). Moreover this study found a dose-wise effect, with remission occurring more often the longer participants remained engaged in befriending. Evaluation of comparison samples suggested good levels of generalisability (Harris et al., 1999b). A companion paper challenged these findings, finding that 18 original controls who were later offered befriending were no more likely to experience remission than a new control group (Harris et al., 1999b), but this smaller sample was likely to have had more resistant depression, having been remission-free for two years – twice as long as the original sample.

The different findings of these studies may reflect sample differences. Participants in Davidson et al.'s study had mild levels of depression on average, with depression typically secondary to other severe conditions, whereas individuals were excluded from Harris et al.'s study if they had severe conditions comorbid with depression. Therefore these results may suggest that befriending is more effective in reducing

depressive symptoms among SEMI patients for whom chronic depression is the main problem than for those with other or comorbid SEMI conditions.

The companion paper by Harris et al. (1999b) investigated predictors of remission in the original sample of 86 chronically depressed women and found that befriending was one of four factors predicting remission, with a similar predictive power to that of attachment style and the absence of new major life stressors. However, the largest factor in predicting remission was the presence of 'fresh start' experiences – positive life events giving hope. Further analysis revealed that befriending was most effective for women who had no 'fresh start' experiences and also had severe interpersonal or life stressors, significantly increasing their chances of remission from 4% to 36%, compared to controls. By contrast, befriending did not affect the chances of remission for women who were free from major life stressors or experienced 'fresh start' experiences. Due to the limited sample size (N=86), replication is needed to draw conclusions about which groups may benefit most from befriending.

#### *1.4.1.4.2 Psychosocial and Functional Outcomes*

Two studies investigated psychosocial and functional outcomes of befriending. Davidson et al. (2004) found no effects between groups or over time for general wellbeing or social functioning and although self-esteem and global functioning increased over time this occurred in all conditions, including the control group. Importantly the findings of this study were affected by high levels of non-



adherence, with more than one third of participants in the treatment conditions (N=69) not meeting regularly with their volunteers. Post-hoc analyses comparing the SU and non-SU volunteer groups led the authors to conclude that on measures of social functioning, self-esteem and wellbeing participants assigned non-SU volunteers improved when they met with their volunteers, whereas those assigned SU volunteers improved if they did not meet with their volunteers. However, these findings were based on post-hoc tests and the researchers failed to adjust for type-1 error. Therefore, although these results appear to suggest that clients with SEMI may not find it helpful to meet with SU volunteers, this finding should be treated with caution.

Wellbeing was also investigated by McCorkle et al. (2008) using an index combining measures of recovery, self-esteem, hope, quality of life, meaning of life and empowerment. They found no significant group differences in wellbeing between treatment and control groups after six and 12 months of befriending, although there was a highly significant improvement in subjective wellbeing for the 23% of participants classified as treatment responders.

This study also investigated social support, for which there were highly significant group differences between the treatment and control conditions, increasing from six to 12 months and suggesting a dose-wise relationship between befriending and perceived social support. However, as McCorkle et al. (2008) recognise, in providing a befriending intervention social support was manipulated as the dependent variable, therefore it is debatable whether measuring improvements in

perceived social support is valid or simply amounts to checking that the dependent variable has been successfully manipulated.

#### ***1.4.1.5 Summary***

The few studies investigating volunteer befriending for clients with SEMI have been of variable methodological quality. Although qualitative studies have provided detailed descriptions of the experience of befriending, evidence from these studies has been limited by focussing on successful matches.

Participants offered befriending seem to consistently report high levels of satisfaction with the intervention offered. However there is little evidence that befriending results in significant improvements in clinical or psychosocial outcomes, except for social support, which is directly manipulated by the intervention. Acceptability may also be a problem; some studies have found that relatively few potential participants are interested in befriending and participants often disengage early-on, with the proportion of clients failing to complete their course of befriending ranging from 13% to 60% across three quantitative studies.

Although current evidence is mixed, it appears that those responding positively to volunteer befriending experience few drawbacks and may derive a wide range of benefits, experiencing clinical, functional and psychosocial improvements. Perhaps the best evidence of this is provided by qualitative studies of client and volunteer experiences. Qualitative studies have suggested that the benefits of befriending may increase over time as friendship deepens, but with only one study examining

matches lasting beyond one year there is a lack of evidence to substantiate this claim.

Initial evidence suggests that in successful matches volunteers derive similar benefits from befriending as clients. Moreover, in successful matches SU volunteers appear to offer additional benefits for clients, although one large study has raised concerns that in general clients may benefit less from meeting regularly with SU volunteers than from non-SU volunteers.

#### **1.4.2 Studies of Befriending as a Control Therapy**

##### ***1.4.2.1 Overview of Studies***

Thirteen quantitative studies investigated befriending as a control or comparison therapy for CBT. These studies comprised five core studies evaluating the effectiveness of CBT compared to befriending and eight re-evaluation studies which further explored data from samples used in core studies. Thus there were only five unique samples in this section of the review. Two core studies used variants on CBT: the ACE trial (Jackson et al., 2008) used 'Active Cognitive Therapy for Early Psychosis' (ACE), while the TORCH trial used CBT combined with strategies from Acceptance and Commitment Therapy (ACT) (Shawyer et al., 2012). The latter was the only study to use a wait list control group in addition to befriending. The TORCH study recruited participants with psychotic disorders, the majority of whom had schizophrenia, whereas in the other four core studies all participants were diagnosed with schizophrenia.

In all studies participants were not matched to their therapist but were seen by paid mental health professionals. In all studies befriending was based upon a similar model, typically attributed to Sensky et al. (2000) and designed to control for therapist contact in CBT. Befriending sessions were described as *non-directive discussions on neutral topics such as hobbies and interests*. Therapists were empathic but carefully avoided discussion about clinical matters or symptoms. Sessions did not typically involve engaging in activities with the client, but in two core studies neutral activities such as board games, walking or sports could be used to support further discussion of neutral topics (Jackson et al., 2008; Shawyer et al., 2012). Manualised versions of befriending therapy (Bendall, Killackey, Jackson, & Gleeson, 2003; Sensky et al., 2000) were used in three core studies (Jackson et al., 2008; Sensky et al., 2000; Shawyer et al., 2012). Befriending sessions were closely matched to the format of CBT sessions, ranging from weekly to fortnightly in frequency and lasting between 45 minutes and one hour. The duration of befriending ranged widely from two to nine months, with averages ranging from six to 19 sessions.

This review will first consider evidence for the comparative effectiveness of CBT and befriending on various outcomes and factors predicting outcome in these therapies. It will then examine evidence for the appropriateness of befriending as a control therapy.

#### ***1.4.2.2 Studies Comparing the Effects of CBT and Befriending***

The five core studies evaluating the effectiveness of CBT compared with befriending varied considerably in methodological quality, ranging from scores of 49% to 88%. Among these studies the strongest evidence is provided by a blinded RCT known as the London-Newcastle (LN) study (Sensky et al., 2000). This was a moderately sized trial which used several outcomes to evaluate the efficacy of CBT compared with befriending for patients with schizophrenia resistant to medication. This study is of a very high methodological quality and had both the largest sample (N=90) and the longest intervention (9 months). Consequently it has become a benchmark study, with its data extended through re-analysis or follow-up by five other studies.

Each of the remaining four core studies suffered from being significantly underpowered, increasing the likelihood of sample bias as well as type-2 error and restricting generalisability. Among these studies the ACE and TORCH trials had moderately sized samples and were of a good standard (Jackson et al., 2008; Shawyer et al., 2012), while the remaining two studies had very small samples and were of a poor standard (de Paiva Barretto et al., 2009; Turkington & Kingdon, 2000). In light of the variable quality of evidence, findings from the LN study will be presented first, where available, with the findings of other studies compared against them.

#### *1.4.2.2.1 Clinical Outcomes:*

##### *General Psychiatric Outcomes*

The LN study found no differences between befriending and CBT after nine months of treatment, with both groups improving significantly in overall psychiatric symptoms (Sensky et al., 2000). However at nine-month follow-up there was a significant difference between groups, with the CBT group continuing to improve and the befriending group losing some of their gains. A five year follow-up study confirmed this trend, finding that the scores for the CBT group remained significantly lower than those of the befriending group (Turkington et al., 2008). While this follow-up study suffered a considerable attrition rate of 34%, its sample did not differ significantly from those lost to follow-up.

By contrast, the two other studies investigating effects on psychiatric symptoms contradicted the LN study's pattern of results, finding no significant improvements in the befriending group and significant group differences at the end of treatment (Turkington & Kingdon, 2000), but not at follow-up (de Paiva Barretto et al., 2009). However the short length of interventions and small size of the befriending groups (N=6 and N=9 participants respectively) meant that these studies lacked power to detect changes in the befriending groups.

Two studies investigated predictors of overall psychiatric symptom change by reanalysing the LN study data. Samarasekera et al. (2007) examined the befriending group only and found that control and persecutory delusions at baseline predicted improvement at follow-up, whereas baseline auditory hallucinations predicted no improvement at follow-up. The second study found that low anxiety at baseline predicted positive outcomes in overall psychiatric

symptoms in both the befriending and CBT groups (Bateman, Hansen, Turkington, & Kingdon, 2007).

### Psychosis

On measures of negative symptoms and 'schizophrenia change' the LN study found the same pattern of results as before, with both CBT and befriending groups improving significantly at treatment end but then diverging at nine-month follow-up with continued improvement in the CBT group and worsening in the befriending group (Sensky et al., 2000). Five-year follow-up found that the CBT group had maintained significantly lower levels of negative symptoms than the befriending group but group differences had disappeared on the 'schizophrenia change' measure (Turkington et al., 2008).

Two other studies used measures of positive and negative symptoms of psychosis (Jackson et al., 2008; Shawyer et al., 2012), with Shawyer et al. also using measures relating to command hallucinations. These studies supported the LN study's findings of both CBT and befriending groups improving at treatment end without significant group differences, although unlike the LN study these studies did not find significant group differences at follow-up either (Jackson et al., 2008; Shawyer et al., 2012). However it should be noted that these studies used much shorter treatments of 3-4 months in comparison to the 9 month treatments in the LN study, which may explain the greater benefit for the LN CBT group.

The TORCH study found that, when combined, the ACT/CBT and befriending treatments were significantly more beneficial than the control condition on most measures. ACT/CBT and befriending produced a differential pattern of benefits across various measures relating to command hallucinations (CHs). Surprisingly befriending produced the greatest increases in acceptance and coping with CHs, leading the authors to suggest that befriending may help ground patients in reality and distract from symptoms such as CHs (Shawyer et al., 2012).

One smaller study contradicted these results finding that CBT fared better overall on measures of psychosis (de Paiva Barretto et al., 2009), but as noted this study lacked power, particularly in the befriending group.

Only one study investigated predictors of outcome in psychotic symptoms. This study re-analysed the ACE trial and found that outcome in the CBT group was predicted by functioning, avolition and education. By contrast, only premorbid adjustment predicted outcome in the befriending group (Allott et al., 2011). These findings indicate possible differences in the client groups benefitting from CBT and befriending.

### Depression

The LN study found the same pattern in depression scores as in general psychiatric symptoms, with both groups showing significant improvement at treatment end but a significant difference emerging at nine-month follow-up (Sensky et al., 2000).



However at five year follow-up these group differences had disappeared with both groups maintaining gains (Turkington et al., 2008).

One other study found a similar pattern of results at treatment end, with improvements in both the CBT and befriending groups (Turkington & Kingdon, 2000). While improvements were only significant in the CBT group, this study lacked power to find improvements in the befriending group.

### Anxiety

A re-analysis of the LN study found the same pattern in scores for anxiety levels as found on other measures, with both groups improving significantly at treatment end but group differences emerging at nine-month follow-up with the CBT group improving further and the befriending group losing gains (Naeem, Kingdon, & Turkington, 2006).

### Risk

A re-analysis of suicidal ideation in the LN study found reductions in suicidal thoughts in both groups but these reductions were only statistically significant in the CBT group at treatment end and follow-up, with significant group differences at both points (Bateman et al., 2007). However, it should be noted that this study was based on a single item drawn from a larger measure and that the level of suicidal

ideation was relatively low in this sample, therefore the reliability of this measure and the power to find reductions in suicidal ideation were limited.

Two analyses of the number and duration of hospitalisations during follow-up found no significant differences between treatment groups on either measure, both for one year follow-up of the ACE trial (Jackson et al., 2008) and five year follow-up of the LN study (Turkington et al., 2008).

#### *1.4.2.2.2 Functional and Psychosocial Outcomes:*

##### *Quality of Life*

Two studies compared CBT and befriending on measures of Quality of Life (QoL). The TORCH study found no significant group differences between ACT/CBT and befriending, although when combined the treatment groups fared significantly better than the wait list control group. On individual QoL measures of 'general activities' and 'life satisfaction' there were more significant improvements for the ACT/CBT group (Shawyer et al., 2012). This pattern of findings was mirrored in a smaller study which similarly found improvements in both groups, but significant improvements in only the CBT group (de Paiva Barretto et al., 2009).

##### *Functioning*

On measures of functioning the TORCH study found significant improvement in the ACT/CBT group at six-month follow-up, but not in the befriending group. However

there were no significant group differences between ACT/CBT and befriending or between the combined treatments and the wait list control group (Shawyer et al., 2012). Conversely the ACE study found that the CBT group significantly outperformed befriending seven weeks into a three month treatment but the befriending group gradually caught up, with group differences disappearing at one-year follow-up (Jackson et al., 2008).

A re-analysis of the ACE study which investigated predictors of outcome in functioning found that for the befriending group functioning was predicted only by premorbid adjustment, whereas for the CBT group functioning was predicted by baseline work status (Allott et al., 2011).

#### *1.4.2.2.3 Summary*

The evidence regarding the comparative effectiveness of these interventions is severely undermined by methodological limitations relating to power, over-sampling and the absence of control conditions other than befriending. However, despite these limitations the available data does indicate some general trends emerging. On a wide range of clinical outcomes befriending does not appear to produce significantly worse outcomes than CBT at treatment end, although effects for CBT are generally stronger and sometimes more durable. Interestingly the best quality studies have found the most comparable effects for befriending as compared with CBT.

The only study to include an additional control condition identified significant but differential effects for CBT and befriending, suggesting that both befriending and CBT are active treatments, but ones which may have different active ingredients. This conclusion is further supported by studies examining predictors of outcome, which have found different predictors for CBT and befriending.

### **1.4.2.3 The Appropriateness of Befriending as a Control Therapy for CBT**

#### **1.4.2.3.1      *Common Factors***

Several studies have investigated the nature of befriending to determine its effectiveness as a control therapy in trials of CBT.

In an extension of the ACE trial Bendall et al. (2006) investigated the extent to which befriending therapy achieves its intended aim of controlling for ‘common factors’ associated with positive outcomes in therapy. They investigated acceptability (measured as satisfaction and attrition rates), expectancy and time in therapy. No significant differences emerged between befriending and CBT in expectancy or acceptability. These findings are supported by the LN and TORCH studies, which respectively found no differences between CBT and befriending in satisfaction (Sensky et al., 2000), engagement or therapeutic alliance (Shawyer et al., 2012).

In terms of time spent in therapy Bendall et al. (2006) found no differences between groups in the number of sessions but the CBT group spent significantly

more time in sessions overall. These findings are partly contradicted by the LN and TORCH studies, which found no significant differences in either number of sessions or total time in sessions (Sensky et al., 2000; Shawyer et al., 2012). However these differences may relate to sample differences. Bendall et al. (2006) suggest that their sample of young people experiencing first-episode psychosis may have found undirected befriending interactions more difficult to tolerate for whole sessions than more directive CBT techniques.

#### *1.4.2.3.2 Convergent and Divergent Validity*

Another way of assessing the effectiveness of befriending as a control condition is by investigating convergent and divergent validity and by testing for therapy contaminations. Several studies have attempted this using a standard cognitive therapy rating scale (Bendall et al., 2013; Jackson et al., 2008; Sensky et al., 2000) or an adapted version for psychosis (de Paiva Barretto et al., 2009; Shawyer et al., 2012). The independent raters in these studies did not misidentify any befriending sessions as being CBT sessions and where reported there were highly significant differences in scores on cognitive therapy scales between groups. However as Bendall et al. (2013) recognise, such scales are insensitive to control therapy adherence, only assessing CBT strategies.

Bendall et al. (2013) created a purpose-built measure with subscales for CBT and befriending. This measure found evidence of treatment contamination in both CBT and befriending sessions, although these contaminations suggested sensitive

practice rather than significant deviations from the models. When this measure was adapted and used in the TORCH study, no contaminations were found in either the ACT/CBT or befriending groups (Shawyer et al., 2012).

One final study investigated convergent and divergent validity, comparing recordings of befriending sessions from the LN study with CBT sessions from the same trial and recordings of social support interactions between psychiatric inpatients and hairdressers (Milne, Wharton, James, & Turkington, 2006). Using a validated measure of social support this study found significant differences between CBT and befriending sessions, with the groups loading on different subscales of social support. Scores for befriending sessions were strongly correlated with the scores for social support sessions ( $r=0.7$ ). While the evidence provided in this study is undermined by the use of a small and biased sample, it suggests that befriending control therapy may be considered a form of social support, for which there is an existing evidence base.

#### *1.4.2.3.3 Summary*

Taken together these studies suggest that befriending therapy is a highly effective control therapy for common factors in therapy and shows very little overlap with CBT techniques beyond common factors, although it does also appear to offer something distinct from CBT in the form of unstructured social support.

## **1.5 Discussion**

### **1.5.1 Summary of Findings**

This review has explored the findings of twenty studies evaluating befriending interventions for individuals with SEMI.

#### ***1.5.1.1 Volunteer Befriending***

Very few studies have investigated volunteer befriending for clients with SEMI. Among these studies, those using quantitative designs have found little evidence that befriending results in greater improvements in outcomes than treatment as usual. The only exception is that among the sub-group of chronically depressed women there is initial evidence of befriending increasing chances of remission, particularly for those with adverse life circumstances. This is consistent with the findings of the existing meta-analysis of befriending for depression and distress (Mead et al., 2010). However beyond this group the only outcome affected by befriending was social support, which is directly manipulated by the social contact involved in befriending interventions.

Nevertheless qualitative studies recruiting participants from successful befriending matches provide rich data to suggest that both clients and volunteers may experience a wide range of clinical, psychosocial and functional benefits as a result of befriending. One way in which successful befriending matches appear to benefit clients is through allowing them to escape from feeling defined by their identity as a

service user and to feel accepted by a member of the wider community. Similar findings were reported in a recent review of volunteering for severe mental illness, which found that one of the main benefits for clients was gaining a non-stigmatising companion who helped them to increase their involvement in the community (Hallett et al., 2012). As previously noted, similar benefits have also been reported in the wider literature investigating befriending in other populations.

#### ***1.5.1.2 Befriending as a Control Condition***

Studies utilising befriending as a control condition in trials of CBT for SEMI have found mixed results, although some common themes were apparent. The strongest evidence suggests that befriending offers comparable benefits to CBT, although the effects produced by CBT are often larger or more durable. However oversampling, a lack of power and a dearth of control conditions with which to compare befriending make it difficult to draw firm conclusions about comparative effectiveness.

Current evidence suggests that befriending is a very effective control for the 'common features' of therapy, but it also appears to offer a distinct therapeutic intervention with different active ingredients, such as social support. In engaging clients in discussion about interests and recreational activities, befriending control therapy (BCT) bears some resemblance to solution-focussed approaches to therapy (e.g. Macdonald, 2007).



### ***1.5.1.3 Comparing Two Types of Befriending***

The finding in this review that BCT performed similarly to CBT, an established therapy for psychosis, suggests that this form of befriending was more effective in producing therapeutic change than volunteer befriending. One explanation for this difference is that attrition rates were lower among participants receiving BCT than those receiving volunteer befriending. This suggests that the experienced professionals delivering BCT were better able to engage clients with SEMI than lay volunteers. However when volunteers successfully engaged clients the benefits appeared to be considerable, with clients appreciating having contact with an accepting non-professional from the community, offering a different quality of support than their regular contact with mental health services (Davidson et al., 2001; McCorkle et al., 2009). Another explanation for the difference in results is that BCT appears to have involved several core therapy techniques, such as unconditional positive regard and empathy (Samarasekera et al., 2007) which are less likely to have been provided by volunteers. Thus BCT, which typically involves less engagement in community-based activities, may be more akin to supportive therapy than to volunteer befriending. Certainly the findings for BCT in this review are similar to those of the recent meta-analysis which found no significant differences in outcomes between CBT and supportive therapy (Newton-Howes & Wood, 2013).

### **1.5.2 Limitations**

### ***1.5.2.1 Limitations of The Literature and Recommendations for Further Research***

#### ***1.5.2.1.1 Volunteer Befriending***

The quantitative studies of volunteer befriending considered in this review incurred considerable attrition, with up to 60% of participants not receiving a full course of befriending and many participants failing to engage beyond the first session.

However, in clinical practice SUs electing to receive befriending might be more motivated to remain engaged in befriending, having chosen the intervention rather than being recruited and randomised to receive it. Moreover, while unsuccessful matches resulted in disengagement in studies, in practice individuals would be likely to be re-matched if they struggled to engage with their first volunteer.

Therefore RCTs are likely to underestimate the effectiveness of volunteer befriending. In order to more realistically measure the effectiveness of befriending in practice, future studies could employ more naturalistic designs. For instance McCorkle et al. (2008) recruited participants from the waiting list of an existing befriending service.

A further limitation affecting studies of volunteer befriending was the length of interventions. Participants in qualitative studies of volunteer befriending reported increasing benefits over time as friendship developed, but only one study has included participants matched for more than one year. Again this suggests that existing studies may underestimate the effectiveness of volunteer befriending. Further research is needed to investigate the longer-term impact of volunteer befriending.

#### **1.5.2.1.2      *Befriending Control Therapy***

The primary weakness of studies of BCT was the absence of control conditions in all but one study. Without control conditions it is not possible to identify whether changes observed in the BCT groups were caused by the intervention or other factors such as spontaneous remission or the placebo effect.

The use of befriending as a control condition is also problematic as clinicians delivering control conditions may have lower expectancy for the intervention and its outcomes (Mead et al., 2010).

#### **1.5.2.1.3      *Overall Limitations***

A problem affecting both forms of befriending was oversampling, with the twenty papers synthesised in this review derived from only ten unique samples. This issue was particularly problematic in studies of BCT, in which the samples of the LN and ACE trials accounted for ten of the thirteen papers reviewed. This degree of oversampling risks placing too great an emphasis on the findings from individual cohorts of participants. Thus cohort effects may have biased the findings of this review. Clearly there is a need for more original research investigating befriending interventions for SEMI.

#### **1.5.2.2 *Limitations of This Review***

Although befriending may be considered a ‘simple’ intervention it is hard to define what constitutes a befriending intervention (Mead et al., 2010). Many psychosocial interventions involve elements of unstructured social support similar to that provided in befriending. In the research literature ‘befriending’ may refer to volunteer befriending, BCT or crisis telephone lines. However in clinical practice it is typically associated with volunteer befriending. Consequently the inclusion of BCT, delivered by paid professionals, in this review may be seen as controversial. Nevertheless both interventions fulfil the definition of befriending provided by Dean and Goodlad (1998) and there are many similarities between BCT and volunteer befriending. These similarities include the provision of unstructured social support, companionship and a non-judgemental approach.

An alternative approach to this review would have been to include other interventions involving core elements of befriending, such as ‘peer-support’ interventions. However if such an approach were taken it would be very difficult to define the limits of befriending and to decide which interventions to review.

### **1.5.3 Implications for Practice**

#### ***1.5.3.1 Volunteer Befriending***

On the basis of current research volunteer befriending appears best suited as a supplementary treatment option offered to socially isolated individuals desiring greater social integration. In providing increased social support for these individuals it may be seen as a cost-effective treatment.

The findings of this review suggest that befriending delivered by trained clinicians has a greater effect than volunteer befriending. It is therefore possible that the benefits of volunteer befriending might be enhanced for individuals with SEMI by training volunteers in basic counselling skills such as empathic listening.

#### ***1.5.3.2 Befriending Control Therapy***

Although limited by a lack of original research, studies of BCT highlight the potential benefits of unstructured social support provided for individuals with SEMI.

While BCT does not offer a more cost-effective treatment option than CBT, it may be more accessible for some clients preferring a less structured approach.

Therefore BCT may be considered alongside other similar non-directive interventions, such as supportive therapy, as an alternative to CBT.

#### **1.5.4 Conclusion**

This systematic review has examined twenty studies investigating befriending interventions for SEMI. Initial findings suggest that volunteer befriending provides social support for individuals with SEMI but has limited clinical benefit. By contrast BCT appears to offer short-term benefits comparable to CBT. Thus BCT represents a distinct intervention, rather than simply controlling for common factors in therapy. However these findings should be treated with caution as current evidence is severely limited by methodological limitations and a dearth of original research.

## References:

- Allott, K., Alvarez-Jimenez, M., Killackey, E. J., Bendall, S., McGorry, P. D., & Jackson, H. J. (2011). Patient predictors of symptom and functional outcome following cognitive behaviour therapy or befriending in first-episode psychosis. *Schizophrenia Research*, 132(2-3), 125-130. doi: <http://dx.doi.org/10.1016/j.schres.2011.08.011>
- Bateman, K., Hansen, L., Turkington, D., & Kingdon, D. (2007). Cognitive behavioral therapy reduces suicidal ideation in schizophrenia: Results from a randomized controlled trial. *Suicide and Life-Threatening Behavior*, 37(3), 284-290. doi: <http://dx.doi.org/10.1521/suli.2007.37.3.284>
- Bendall, S., Allott, K., Jovev, M., Marois, M.-J., Killackey, E. J., Gleeson, J. F., . . . Jackson, H. J. (2013). Therapy Contamination as a Measure of Therapist Treatment Adherence in a Trial of Cognitive Behaviour Therapy versus Befriending for Psychosis. *Behavioural and Cognitive Psychotherapy*, 1-14.
- Bendall, S., Jackson, H. J., Killackey, E., Allott, K., Johnson, T., Harrigan, S., . . . McGorry, P. D. (2006). The Credibility and Acceptability of Befriending as a Control Therapy in a Randomized Controlled Trial of Cognitive Behaviour Therapy for Acute First Episode Psychosis. *Behavioural and Cognitive Psychotherapy*, 34(3), 277-291. doi: <http://dx.doi.org/10.1017/S1352465806002815>
- Bendall, S., Killackey, E., Jackson, H. J., & Gleeson, J. (2003). *Befriending Manual*. Melbourne, Australia: ORYGEN Research Centre.
- Bentall, R. P. (2009). *Doctoring the mind : why psychiatric treatments fail*. London, England; New York, N.Y.: Allen Lane.
- Bradshaw, T., & Haddock, G. (1998). Is befriending by trained volunteers of value to people suffering from long-term mental illness? *Journal of Advanced Nursing*, 27(4), 713-720.
- British Psychological Society. (2002). Briefing Paper 18 - Clinical Psychology in Services for People with Severe and Enduring Mental Illness Retrieved 2nd May, 2014, from [http://dcp-sigpr.bps.org.uk/dcp-sigpr/publications/briefing\\_papers.cfm](http://dcp-sigpr.bps.org.uk/dcp-sigpr/publications/briefing_papers.cfm)
- Caldwell, K., Henshaw, L., & Taylor, G. (2011). Developing a framework for critiquing health research: An early evaluation. *Nurse Education Today*, 31(8), e1-e7. doi: <http://dx.doi.org/10.1016/j.nedt.2010.11.025>
- CASP. (2013). CASP Checklists. Retrieved 3rd May, 2014, from <http://www.casp-uk.net/#!/casp-tools-checklists/c18f8>
- Charlesworth, G., Shepstone, L., Wilson, E., Reynolds, S., Mugford, M., Price, D., . . . Poland, F. (2008). Befriending Carers of People with Dementia: Randomised Controlled Trial. *BMJ (British Medical Journal)*, 336(7656), 1295-1297. doi: <http://dx.doi.org/10.1136/bmj.39549.548831.AE>
- Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, 6(2), 165-187. doi: <http://dx.doi.org/10.1093/clipsy/6.2.165>
- Davidson, L., Haglund, K. E., Stayner, D. A., Rakfeldt, J., Chinman, M. J., & Kraemer Tebes, J. (2001). "It was just realizing...that life isn't one big horror": A

- qualitative study of supported socialization. *Psychiatric Rehabilitation Journal*, 24(3), 275-292. doi: <http://dx.doi.org/10.1037/h0095084>
- Davidson, L., Shahar, G., Stayner, D. A., Chinman, M. J., Rakfeldt, J., & Tebes, J. K. (2004). Supported Socialization for People With Psychiatric Disabilities: Lessons From a Randomized Controlled Trial. *Journal of Community Psychology*, 32(4), 453-477. doi: <http://dx.doi.org/10.1002/jcop.20013>
- de Paiva Barretto, E. M., Kayo, M., Avrichir, B. S., Sa, A. R., Camargolutti, M. d. G. M., Napolitano, I. C., . . . Elkis, H. (2009). A preliminary controlled trial of cognitive behavioral therapy in clozapine-resistant schizophrenia. *Journal of Nervous and Mental Disease*, 197(11), 865-868. doi: <http://dx.doi.org/10.1097/NMD.0b013e3181be7422>
- Dean, J., & Goodlad, R. (1998). The role and impact of befriending (summary): Joseph Rowntree Foundation.
- Department of Health. (1999). *National Service Framework for Mental Health*. [London]: Dept. of Health.
- Draper, M. L., Velligan, D. I., & Tai, S. (2010). Cognitive behavioral therapy for schizophrenia: A review of recent literature and meta-analyses. *Minerva Psichiatrica*, 51(2), 85-94.
- Greenhalgh, T. (2010). How to read a paper the basics of evidence-based medicine.
- Hallett, C., Klug, G., Lauber, C., & Priebe, S. (2012). Volunteering in the care of people with severe mental illness: a systematic review. *BMC Psychiatry*, 12(1), 226. doi: <http://dx.doi.org/10.1186/1471-244X-12-226>
- Harris, T., Brown, G. W., & Robinson, R. (1999a). Befriending as an intervention for chronic depression among women in an inner city: 1: Randomised controlled trial. *The British Journal of Psychiatry*, 174, 219-224. doi: <http://dx.doi.org/10.1192/bjp.174.3.219>
- Harris, T., Brown, G. W., & Robinson, R. (1999b). Befriending as an intervention for chronic depression among women in an inner city: 2: Role of fresh-start experiences and baseline psychosocial factors in remission from depression. *The British Journal of Psychiatry*, 174, 225-232. doi: <http://dx.doi.org/10.1192/bjp.174.3.225>
- Jackson, H. J., McGorry, P. D., Killackey, E., Bendall, S., Allott, K., Dudgeon, P., . . . Harrigan, S. (2008). Acute-Phase and 1-Year Follow-Up Results of a Randomized Controlled Trial of Cbt Versus Befriending for First-Episode Psychosis: The ACE Project. *Psychological Medicine*, 38(5), 725-735. doi: <http://dx.doi.org/10.1017/S0033291707002061>
- Jones, C., Hacker, D., Cormac, I., Meaden, A., & Irving, C. B. (2012). Cognitive behavior therapy versus other psychosocial treatments for schizophrenia. *Schizophrenia Bulletin*, 38(5), 908-910. doi: <http://dx.doi.org/10.1093/schbul/sbs090>
- Kersley, H., Estep, B., & Leadley, J. (2014). Relationships for children in care: The value of mentoring and befriending: New Economics Foundation. Retrieved 7<sup>th</sup> August, 2014 from <http://www.neweconomics.org/publications/entry/relationships-for-children-in-care>
- Macdonald, A. J. (2007). Solution-focused therapy theory, research & practice. from <http://public.eblib.com/EBLPublic/PublicView.do?ptiID=435384>

- McCorkle, B. H., Dunn, E. C., Wan, Y. M., & Gagne, C. (2009). Compeer friends: A qualitative study of a volunteer friendship programme for people with serious mental illness. *International Journal of Social Psychiatry*, 55(4), 291-305. doi: <http://dx.doi.org/10.1177/0020764008097090>
- McCorkle, B. H., Rogers, E. S., Dunn, E. C., Lyass, A., & Wan, Y. M. (2008). Increasing social support for individuals with serious mental illness: Evaluating the Compeer model of intentional friendship. *Community Mental Health Journal*, 44(5), 359-366. doi: <http://dx.doi.org/10.1007/s10597-008-9137-8>
- Mead, N., Lester, H., Chew-Graham, C., Gask, L., & Bower, P. (2010). Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. *The British Journal of Psychiatry*, 196(2), 96-101. doi: <http://dx.doi.org/10.1192/bjp.bp.109.064089>
- Mentoring and Befriending Foundation. (2010). Befriending Works: Building Resilience in Local Communities. Retrieved 7<sup>th</sup> August, 2014 from <http://www.mandbf.org/resources/design-planning-and-funding/befriending-works-building-resilience-in-local-communities-a-report-into-an-intervention-that-can-help-improve-health-and-well-being-at-all-levels-of-need>
- Mentoring and Befriending Foundation. (2014). What is Mentoring and Befriending? Retrieved 3rd May, 2014, from <http://www.mandbf.org/training-and-events/resources/design-planning-and-funding/what-is-mentoring-and-befriending>
- Milne, D., Wharton, S., James, I., & Turkington, D. (2006). Befriending versus CBT for schizophrenia: A convergent and divergent fidelity check. *Behavioural and Cognitive Psychotherapy*, 34(1), 25-30. doi: <http://dx.doi.org/10.1017/S1352465805002456>
- Naeem, F., Kingdon, D., & Turkington, D. (2006). Cognitive Behaviour Therapy for Schizophrenia: Relationship between Anxiety Symptoms and Therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 79(2), 153-164. doi: <http://dx.doi.org/10.1348/147608305X91538>
- Newton-Howes, G., & Wood, R. (2013). Cognitive behavioural therapy and the psychopathology of schizophrenia: Systematic review and meta-analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 86(2), 127-138. doi: <http://dx.doi.org/10.1111/j.2044-8341.2011.02048.x>
- NICE. (2006). NICE Clinical Guideline 38: Bipolar Disorder - The management of bioplar disorder in adults, children and adolescents, in primary and secondary care. Retrieved 3rd May, 2014, from <http://guidance.nice.org.uk/CG38/Guidance>
- NICE. (2010). NICE Clinical Guideline 90: Depression: The NICE Guideline on The Treatment and Management of Depression in Adults - Updated Edition. Retrieved 3rd May, 2014, from <http://guidance.nice.org.uk/CG90/Guidance>
- NICE. (2014). Psychosis and Schizophrenia in Adults. The NICE Guideline on Treatment and Management. Updated Edition 2014. Retrieved 2nd May, 2014, from <http://guidance.nice.org.uk/CG178/guidance>
- Parabiaghi, A., Bonetto, C., Ruggeri, M., Lasalvia, A., & Leese, M. (2006). Severe and persistent mental illness: a useful definition for prioritizing community-



- based mental health service interventions. *Social psychiatry and psychiatric epidemiology*, 41(6), 457-463.
- Perese, E. F., & Wolf, M. (2005). Combating loneliness among persons with severe mental illness: social network interventions' characteristics, effectiveness, and applicability. *Issues in mental health nursing*, 26(6), 591-609.
- Phillip, K., & Spratt, J. (2007). A synthesis of published research on mentoring and befriending for The Mentoring and Befriending Foundation: University of Aberdeen: The Rowan Group. Retrieved 7<sup>th</sup> August, 2014 from <http://www.mandbf.org/resources/research-and-project-evaluation-directory/a-synthesis-of-published-research-on-mentoring-and-befriending>
- Rathod, S., Kingdon, D., Weiden, P., & Turkington, D. (2008). Cognitive-behavioral therapy for medication-resistant schizophrenia: A review. *Journal of Psychiatric Practice*, 14(1), 22-33. doi: <http://dx.doi.org/10.1097/01.pra.0000308492.93003.db>
- Ruggeri, M., Leese, M., Thornicroft, G., Bisoffi, G., & Tansella, M. (2000). Definition and prevalence of severe and persistent mental illness. *British Journal of Psychiatry*(177), 149-155.
- Sainsbury Centre for Mental Health. (1998). *Keys to engagement : review of care for people with severe mental illness who are hard to engage with services*. London: Sainsbury Centre for Mental Health.
- Samarasekera, N., Kingdon, D., Siddle, R., O'Carroll, M., Scott, J. L., Sensky, T., . . . Turkington, D. (2007). Befriending patients with medication-resistant schizophrenia: Can psychotic symptoms predict treatment response? *Psychology and Psychotherapy: Theory, Research and Practice*, 80(1), 97-106. doi: <http://dx.doi.org/10.1348/147608306X108998>
- Sensky, T., Turkington, D., Kingdon, D., Scott, J. L., Scott, J., Siddle, R., . . . Barnes, T. R. E. (2000). A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry*, 57(2), 165-172. doi: <http://dx.doi.org/10.1001/archpsyc.57.2.165>
- Shawyer, F., Farhall, J., Mackinnon, A., Trauer, T., Sims, E., Ratcliff, K., . . . Copolov, D. (2012). A randomised controlled trial of acceptance-based cognitive behavioural therapy for command hallucinations in psychotic disorders. *Behaviour Research and Therapy*, 50(2), 110-121. doi: <http://dx.doi.org/10.1016/j.brat.2011.11.007>
- Turkington, D., & Kingdon, D. (2000). Cognitive-behavioural techniques for general psychiatrists in the management of patients with psychoses. *The British Journal of Psychiatry*, 177, 101-106. doi: <http://dx.doi.org/10.1192/bjp.177.2.101>
- Turkington, D., Sensky, T., Scott, J., Barnes, T. R. E., Nur, U., Siddle, R., . . . Kingdon, D. (2008). A randomized controlled trial of cognitive-behavior therapy for persistent symptoms in schizophrenia: A five-year follow-up. *Schizophrenia Research*, 98(1-3), 1-7. doi: <http://dx.doi.org/10.1016/j.schres.2007.09.026>

## **Chapter 2: Empirical Paper**

### **Certainty Amidst Confusion: The Experience of Christians Diagnosed with Psychosis.**

**Target Journal:** *British Journal of Psychology*

Word Count: 7950 (excluding abstract\*, tables, figures, quotations and reference list).

\*See Appendix E for Submission Guidelines.

## **2.1 Abstract**

In previous qualitative studies patients with spiritual beliefs have reported feeling that mental health professionals (MHPs) misinterpret their spiritual experiences as psychotic. Since religious delusions often feature Christian narratives, MHPs may have particular difficulty distinguishing between spiritual and psychotic experiences in Christians. This study investigated the experience of Christians with psychosis.

Eight Christians diagnosed with psychosis were interviewed about the relationship between faith and psychosis and their experiences of psychiatric treatment.

Interpretative Phenomenological Analysis produced two superordinate themes.

The first theme describes participants' struggle to find meaning and certainty amidst the confusion of psychotic illness. When faith experiences 'blurred' into illness, faith contributed to this confusion. However faith was also a valuable source of certainty and stability for participants. In the second theme participants described encountering unhelpful attitudes in MHPs and Christians which left them feeling devalued. Participants described MHPs often dismissing or pathologising their faith. In church they often felt stigmatised or judged due to their mental illness. By contrast, when professionals and Christians were accepting and supportive, participants described feeling more fully human.

These findings highlight the importance of MHPs considering patients' spiritual needs and suggest that Christians with psychosis may be a significantly marginalised and misunderstood group.

## **2.2 Introduction**

### **2.2.1 The Importance of Spirituality for Mental Health Service Users**

Spirituality is an important issue for mental health service users, with studies suggesting that 50-80% of service users consider spiritual or religious beliefs an important part of their daily lives (Borras et al., 2007; Mental Health Foundation, 1997; Tepper, Rogers, Coleman, & Malony, 2001). Moreover as Suhail and Ghauri (2010) note, several studies have found that the psychiatric patients hold stronger religious attitudes and beliefs than non-psychiatric patients.

Despite the importance afforded to spirituality by service users, for many years the link between mental health and spirituality appeared to have been neglected in the mental health system (Swinton, 2007). However since the turn of the millennium there has been considerably greater interest in the link between spirituality and mental health, both among researchers and within mental health professions (Clarke, 2001; Cornah, 2006; Swinton, 2007). This change has been attributed to an increasing focus on cultural sensitivity, diversity and accessibility (Pouchly, 2012), the growth in advocacy (Morgan, 2010) and the increasing presence of service users' voices within the research literature (Swinton, 2007).

### **2.2.2 Spirituality and People with Psychosis**

Spirituality provides a variety of benefits for individuals experiencing psychosis, giving hope, meaning and comfort, enabling the reconstruction of an identity and a

sense of self and facilitating reconnection with nature, others and community (Cornah, 2006; Drinnan & Lavender, 2006; Phillips, 2009; Tarko, 2003). However, spirituality may not always be therapeutic for patients with psychosis; a review of 70 studies between 1980 and 2010 concluded that religion interacts with symptoms of hallucination and delusion and can either be a protective factor or a risk factor for patients with schizophrenia (Gearing et al., 2011).

### **2.2.3 Psychotic Symptoms and Spirituality**

Religious delusions are a common experience among patients with psychosis. According to Mills (2001) the most reliable estimate is that 24% of British patients with schizophrenia experience religious delusions. One study (Getz, Fleck, & Strakowski, 2001) has indicated that Christians with psychosis experience religious delusions more frequently and more severely than non-religious patients. However a recent review found no evidence of a causal link between religious beliefs and the development of schizophrenia (Spirituality Forum, 2011).

### **2.2.4 Pathologising Spiritual Experiences**

Several studies have shown that it is difficult to distinguish between spiritual experiences and religious delusions (Eeles, Lowe, & Wellman, 2003; Hunt, 2007; Stifler, Greer, Sneck, & Dovenmuehle, 1993). Given this similarity, Clarke (2001)

argues that psychosis and spirituality should be re-appraised as both representing atypical experiences on a continuum between normal and abnormal experiences.

One consequence of this difficulty in distinguishing spiritual and psychotic experiences is that professionals may mistake spiritual experiences as psychotic. This is indicated in a study by O'Connor and Vandenberg (2010) which found that mental health professionals performed similarly to members of the public in distinguishing religious and harmful beliefs. This suggests that professionals judge patients' beliefs on the basis of social norms rather than diagnostic criteria and therefore may easily mistake unusual spiritual experiences as psychotic. In support of this suggestion Rashd (2010) argues that many of the assumptions and procedures of psychiatry inherently promote the pathologising of unusual experiences such as spiritual experiences.

As Drinnan and Lavender (2006) recognise, the consequences of pathologising patients' beliefs are severe, risking potential mis-diagnosis, unnecessary or prolonged hospital stays and the removal of patient freedoms. Pathologising patients' beliefs also contravenes the NHS's Revised Patient Charter which promises that "staff will be sensitive to and respect your religious spiritual and cultural needs at all times" (2001, p.29, cited by Spirituality Forum, 2011). It may also infringe Article 9 of the Human Rights Act, which states that people should be free to express their religion, whatever this may be or look like.

#### **2.2.5 Studies of Service User Experience**

Two British studies of service user experience have provided further evidence that professionals may pathologise the spiritual experiences of their patients. The first of these studies interviewed 27 mental health service users from Somerset with spiritual beliefs (Mental Health Foundation, 2002). Subsequent grounded theory analysis of eleven participants' interviews indicated that when relatives or professionals rejected or ignored spiritual experiences, participants were unable to find meaning in their experiences, leading to worse outcomes (Macmin & Foskett, 2004). Another study interviewed seven service users from London with psychosis and various religious beliefs (Drinnan & Lavender, 2006). In this study participants explained that previous experiences of having their religious experiences pathologised made them reluctant to speak to professionals about their spirituality.

However beyond these studies the literature on the experience of service users with spiritual beliefs is limited to international studies conducted in Canada (Forchuk, Jewell, Tweedell, & Steinngel, 2003; Smith & Suto, 2012; Tarko, 2003). Therefore with only one British study in the past decade (Drinnan & Lavender, 2006) there is a need for further research into the experience of British service users with spiritual beliefs. Moreover with the recent appearance of a number of policies and organisations promoting spiritually sensitive practices (Spirituality Forum, 2011) it would be beneficial to re-examine the experience of service users. Doing so could help to identify whether patients have experienced a felt improvement in provision for spiritual needs.

#### **2.2.6 Aims and Rationale**

### **2.2.6.1 Rationale**

As Christians appear to experience more religious delusions than service users without spiritual beliefs (Getz et al., 2001) they may be particularly likely to have their beliefs pathologised. This suggestion is supported by previous qualitative studies in which some Christian participants reported that their spiritual experiences were pathologised by professionals (Drinnan & Lavender, 2006; Macmin & Foskett, 2004; Mental Health Foundation, 2002). Given that descriptions of 'typical' religious delusions often involve Christian narratives, such as God, Jesus, the devil and hell, it is possible that mental health professionals may more often label the spiritual experiences of Christian service users as psychotic. Alternatively, the place of Christianity in British cultural heritage and its continuing place in society may normalise Christian beliefs for professionals, reducing the likelihood of Christian service users' beliefs being pathologised, as compared to service users with other spiritual beliefs.

In response to these speculations this study aimed to extend the literature by examining the particular experience of Christians with psychosis. By choosing to restrict the sample to Christians a more homogenous sample was recruited, which was likely to yield more common themes of experience than a sample comprising several spiritual groups. Furthermore in examining the experience of Christians with psychosis this study aimed to give collective voice to the experiences of a minority group whose needs might not otherwise be heard within mental health services.



### **2.2.6.2 Research Aim and Questions**

This study aimed to extend the literature by examining the experiences of Christians with psychosis. More specifically the following research questions were developed.

1. How do Christians with psychosis understand the relationship between their faith and psychosis?
2. How do Christians with psychosis experience mental health treatment and in particular, their interactions with mental health professionals?

## **2.3 Methodology**

### **2.3.1 Design**

In order to capture detailed information about service users' experiences an Interpretative Phenomenological Analysis (IPA) methodology was chosen, using semi-structured interviews. IPA's phenomenological approach, which "involves detailed examination of the participants' lived experience" (Smith & Osborn, 2008, p. 53) is ideally suited to giving voice to the experiences of service users in their own terms. IPA's particular suitability to issues involving complexity (Smith & Osborn, 2008) also indicates its suitability for a study exploring the complex relationship between psychosis and spirituality. The choice to use IPA in this study also extends the literature, since other similar studies have used grounded theory

or thematic analysis (Drinnan & Lavender, 2006; Macmin & Foskett, 2004; Mental Health Foundation, 2002).

### **2.3.2 Recruitment**

#### **2.3.2.1 Sample**

The target population for this study consisted of Christians with a diagnosis of psychosis and a history of at least one psychiatric inpatient admission, reflecting the study's focus on experiences of psychiatric treatment. In accordance with guidance on appropriate sample sizes for IPA (Smith, Flowers, & Larkin, 2009) a sample of eight participants was recruited for this study. It was considered appropriate to begin analysis at this point as the eight interviews had produced a large volume of rich data with common themes clearly emerging across the cohort of participants.

#### **2.3.2.2 Recruitment Procedure**

In order to avoid recruiting participants who were at high risk of becoming acutely unwell, participants were not recruited directly from mental health services. Instead participants were recruited via local service-user groups and mental health charities as it was anticipated that individuals attending such services would be more likely to be experiencing remission from acute psychotic symptoms.

Potential participants were identified by asking organisations to notify their service-users about the opportunity to participate and speaking about the study at

meetings of service-users. In addition, promotional posters and leaflets (*Appendix F*) were displayed at the offices of mental health charities and distributed via the electronic mailing lists of charities and service user groups. In light of the restrictive inclusion criteria of religion, diagnosis and psychiatric history, difficulties were anticipated in recruiting a sufficient sample. Therefore this study also employed a networking approach (Barker, Pistrang, & Elliott, 2002) whereby participants were encouraged to notify other individuals about the opportunity to participate. Unexpectedly networking accounted for only one of the eight participants recruited.

#### ***2.3.2.3 Inclusion and Exclusion of Participants***

Potential participants were excluded if they were currently hospitalised or otherwise judged to be acutely psychotic or in a state of crisis at the point of recruitment or interview. These exclusion criteria were applied to ensure that participants would be able to give informed consent to participate and would feel able to withdraw. Individuals reporting mild or moderate residual psychotic symptoms were not excluded. Two individuals wishing to participate reported belonging to non-mainstream Christian groups. One reported attending The Church of the Latter Day Saints (the Mormon church) and the other reported attending the Spiritualist church. Although these groups are not universally recognised as Christian denominations, both consider the Bible as a holy text and share many beliefs with mainstream Christianity. Since these individuals self-identified as Christians by volunteering for the study and had both previously regularly attended

several mainstream Christian churches they were considered appropriate for inclusion. Self-reported information about sample characteristics was collected using a demographics questionnaire (**Appendix G**) and is provided in **Table 2.1** and **Table 2.2** below.

Age (years) (N=8)	Mean: 46 Range: 27-71
Gender (frequency) (N=8)	Male: 3 Female: 5
Ethnicity (frequency) (N=8)	White (other): 1 White British: 7
Episodes of mental illness (N=7)	Three: 1 Five to Nine: 1 Ten or More: 2 Continuous since it began: 3
Number of inpatient admissions (N=8)	One: 1 Three: 2 Four: 1 Five to Nine: 3 Ten or More: 1
Years since first treatment in a psychiatric hospital or mental health unit. (N=8)	Mean: 18 Range: 5-39
Years since last treatment for psychosis. (N=8)	Mean: 6 Range: 0-32 Mode: 0 (N=5)
Current Christian denomination:	Anglican: 2 Baptist: 1

(N=8)	Catholic: 1 Independent (evangelical): 1 Mormon: 1 Spiritualist: 1 Does not consider self as part of a denomination: 1
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*Table 2.1: Sample demographic information*

<b>Mental Health Problem:</b>	<b>Total participants who reported having experienced this problem.</b>
Psychosis	7 <sup>1</sup>
Schizophrenia	0
Bipolar Disorder	5
Depression	6
Anxiety	7
OCD	1
PTSD	2
Eating Disorder	2
Other	3

*Table 2.2: Frequency of mental health problems reported by participants.*

### 2.3.3 Procedure

Individuals expressing an interest in participation were initially screened in person or by telephone to assess their suitability and their ability to consent to participate.

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<sup>1</sup> One participant did not report having experienced psychosis on the demographics questionnaire. This appears to be an omission as this participant repeatedly spoke about experiencing psychosis during their interview. Moreover all participants had reported being diagnosed with psychosis when screened prior to interview.

Those considered appropriate for inclusion were asked to read the participant information sheet (**Appendix H**) prior to interview.

Individual interviews were conducted in rooms provided by universities and mental health charities. These venues were considered quiet and non-threatening and offered sufficient privacy. Where possible the interview location was familiar to the participant. These arrangements were intended to put participants at ease, supporting them to speak openly about the deeply personal experiences investigated by this study.

Prior to commencing the interview the participant was asked to complete an informed consent form (**Appendix I**) and the demographics questionnaire.

Semi-structured interviews lasted between 57 and 83 minutes and were recorded using an electronic dictaphone. At the end of interviews participants were debriefed to monitor any strong or upsetting feelings evoked by discussing their experiences. Participants were then provided with a debrief sheet (**Appendix J**) and, if necessary, signposted to appropriate support services. Although a minority of participants noted some upsetting feelings arising during interviews, no referrals to support services were necessary following interview.

#### **2.3.4 Materials**

An interview schedule (**Appendix K**) was developed, drawing upon guidance provided by King and Horrocks (2010) and Smith et al. (2009). Questions were

phrased in open and neutral terms to support participants to feel comfortable talking about their personal experiences and opinions. Interview questions were initially drafted to achieve sufficient coverage of the research questions and study aims. The draft interview schedule was discussed with a supervisor with extensive experience in IPA research. It then underwent several revisions in an iterative manner, on the basis of feedback obtained. As recommended by King and Horrocks (2010) the interview schedule was revised during the course of data collection. In accordance with the principles of IPA, priority was given to allowing participants to tell their experiences in their own terms. Consequently the interview schedule was used with a degree of flexibility, particularly as regards the ordering of questions.

All other materials used in this study were developed in consultation with supervisors and redrafted in response to supervisory feedback.

### **2.3.5 Ethical Approval**

Ethical approval was obtained from the Coventry University Applied Research Ethics Committee (**Appendix L**).

### **2.3.6 Analysis**

Recorded interviews were transcribed verbatim and saved in encrypted password-protected documents which were securely stored. Names and other personally identifiable information were anonymised during transcription to protect the

identity of participants. One participant contacted the researcher after interview to request that a portion of their interview be removed from analysis, which was done accordingly.

IPA was conducted in accordance with guidance for the analysis of data from larger samples provided by Smith et al. (2009) and Smith and Osborn (2008). The stages of the analysis process are presented in **Table 2.3**, below. Extracts of coded transcripts and examples of thematic maps are provided in **Appendices M and N**. In keeping with guidance provided by Smith et al. (2009) only themes appearing in the account of at least half the sample were included in the final thematic structure. Due to the restricted length of this report some themes which did not fit within the final thematic structure or appeared less frequently in participants' accounts will not be reported. Nevertheless it was felt that the final thematic structure achieved a good degree of coverage of the themes identified in analysis.

Stage	Stages of initial analysis conducted for each transcript
1	Re-listening to interview recording.
2	Reading and re-reading of the transcript.
3	Coding the transcript with exploratory codes.
4	Coding the transcript with emergent themes.
5	Creation of a visual thematic map to aid coding and facilitate the identification of thematic patterns between participants.
	<b>Stages of analysis once all transcripts had been coded individually</b>
6	Creation of thematic maps of themes for all participants in order to test alternative thematic structures and to identify superordinate themes.
7	Quotations for emergent themes extracted from each participant's transcript and compiled by theme in a single document.



8	Use of quotations document to assess validity and internal consistency of identified themes.
9	Iterative revisions of thematic structure with reference to quotations document and transcripts. Additional quotations obtained from transcripts for newly emerging themes.
10	Stable thematic structure established and used to write the analysis.

Table 2.3: Stages of IPA analysis conducted.

### 2.3.7 Validity

Yardley (2000) presents four principles by which the quality of qualitative research may be assessed: *'sensitivity to context'*, *'commitment and rigour'*, *'transparency and coherence'* and *'impact and importance'*. The researcher has considered these principles throughout the research process. In writing the analysis of this study the researcher also drew upon a guide for assessing the quality of IPA research (Smith, 2011).

Several steps were taken to ensure validity and rigour during the analysis process. At the start of the analysis the first transcript to be coded was also independently coded by a supervisor experienced in IPA research. Exploratory codes and emergent themes were discussed and compared. Later in the analysis this process was repeated with a research student trained in IPA who independently coded a three page extract of a different transcript. During analysis the researcher also met with all three supervisors individually to discuss emerging theme structures. Each of these meetings helped to bring fresh insights to the analysis, highlighting additional themes and theme structures which were then evaluated by returning to

the data. The function of these meetings was similar to that of the 'mini-audit' method of validation described by Smith et al. (2009).

### **2.3.8 Researcher's Position**

King and Horrocks (2010) describe reflexivity as a central process in qualitative research, enabling researchers to become aware of their subjective position and motivations. In doing so they argue that reflexivity enables the researcher to be open to new ideas emerging from their research. To aid the adoption of a reflexive position the researcher wrote reflective accounts after interviews, noting any personal and emotional reactions. Extracts from these accounts are provided in **Appendix O**. Discussions with supervisors throughout the research process also helped to increase reflexive awareness of the researcher's position.

At the time that this research was conducted the researcher was employed as a Trainee Clinical Psychologist. The researcher has a Christian faith and was raised by Christian parents. This study was initially inspired by the researcher forming a personal friendship whilst at church with a Christian service user with psychosis who was subsequently hospitalised. A reflective account of this experience and managing the dual role of psychologist and Christian during the research process forms the basis of Chapter 3.

## **2.4 Analysis**

IPA analysis produced two superordinate themes, each comprising two second-order themes, each with three sub-themes, making a total of twelve sub-themes.

This thematic structure is presented in **Figure 2.1**, below.

The first superordinate theme *“Finding Certainty Amidst Confusion”* describes the confusion resulting from mental illness<sup>2</sup> and participants’ attempts to regain a sense of certainty. This theme is primarily concerned with participants’ internal intrapersonal experiences. By contrast, the second superordinate theme *“Struggle for Acceptance and Personhood”* focuses on participants’ interactions with others, describing the ways in which such interactions impact positively and negatively on participants’ senses of identity and personhood. Thus the second superordinate theme illustrates the potential for interpersonal relationships to either exacerbate or alleviate the confusion described in the first superordinate theme.

In order to give context to participants’ accounts, brief vignettes of the participants recruited for this study are provided in **Table 2.4**, below. Participants have been given pseudonyms to preserve their anonymity.

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<sup>2</sup> Terms such as ‘illness’ and ‘mental illness’ have been used in this report to reflect the language used by participants and in the interests of brevity. Here ‘illness’ is understood in the broadest sense as a point at which a participant was subjectively experiencing psychological distress. Thus ‘illness’ does not equate to meeting psychiatric diagnostic criteria. The use of these terms also indicates that participants’ descriptions did not exclusively refer to experiences of psychosis, but also to experiences of other periods in which they experienced considerable psychological distress.

Pseudonym	Vignette
Alice	A woman with psychotic depression. She attended a mainstream church as a teenager but became disillusioned with church for some time until finding acceptance and community in the Mormon church. She previously trained as a nurse but now helps to run a support group for other service users.
John	A man who worked for many years before experiencing a breakdown involving psychosis and depression. He was brought-up as a Christian and remains involved in his local church but now feels unsure whether to call himself Christian or agnostic. He currently works in mental health.
Helen	A woman with bipolar disorder. She has been a Christian all her life but recently also became interested in Buddhism and describes having many unanswered philosophical questions about faith and psychosis.
Megan	A woman with bipolar disorder. She was quite isolated whilst growing up due to physical health problems but life improved when she recovered enough to go to university where she found supportive Christian friends.
Carol	A divorced woman who previously experienced psychosis alongside depression and anxiety, which she feels were exacerbated by her difficult marriage. She is now involved in voluntary work with mental health and service user organisations.
Toby	A homosexual man with bipolar disorder who explored various churches and religions to find one which would accept him. His turning point was encountering the Spiritualist church, where he finally found a sense of belonging.
Simon	A man with bipolar disorder who experienced religious delusions prior to becoming a Christian. He later experienced a dramatic conversion to faith whilst suicidal which turned his life around. He describes the support he now receives from church and Christian friends as crucial.
Grace	A woman with psychotic depression who previously trained as a doctor but has since had to find less stressful work as a result of her illness. She has been a member of various churches.

*Table 2.4: Participant pseudonyms and vignettes.*

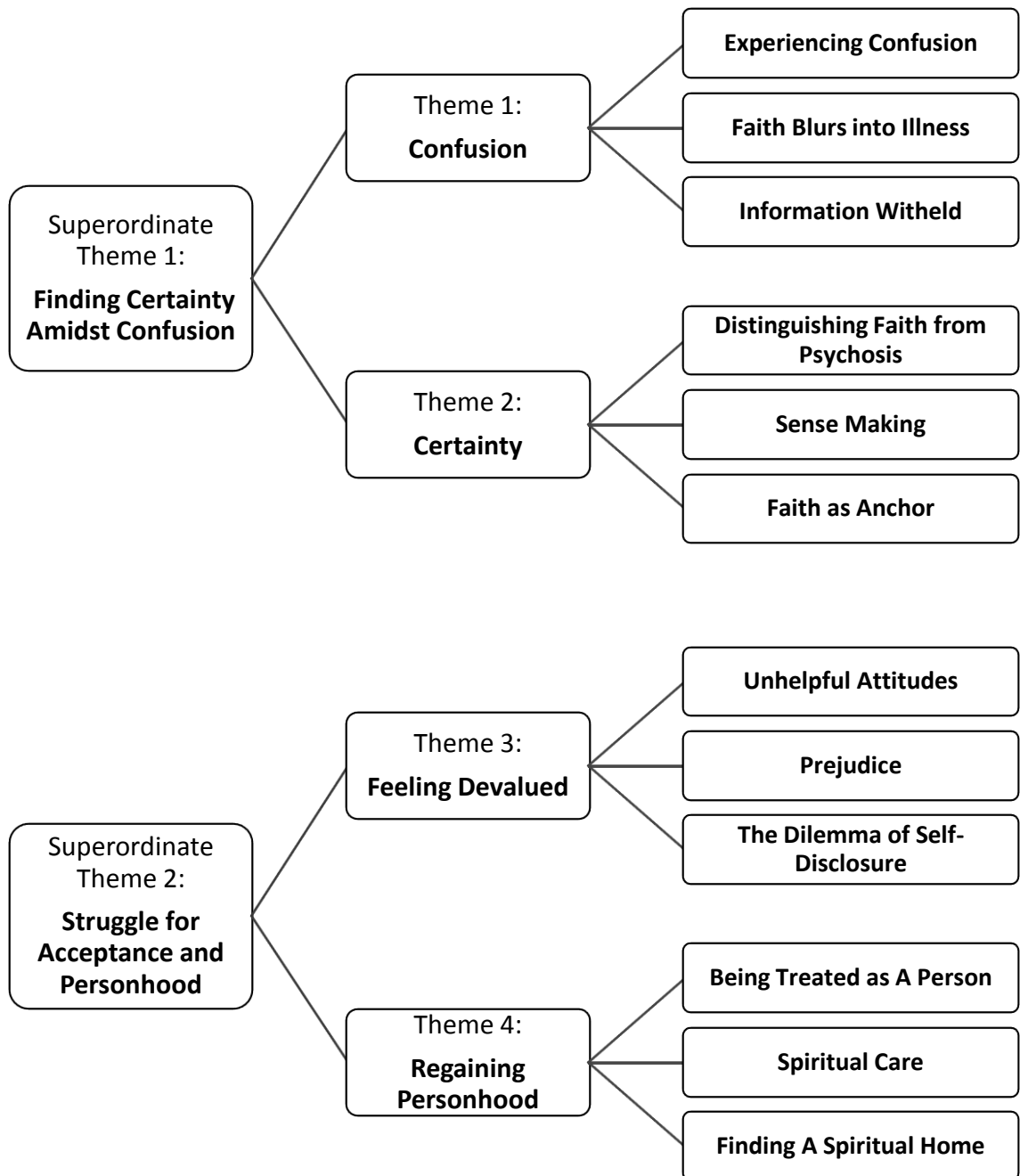


Figure 2.1: Thematic structure produced by IPA analysis.

## **2.4.1 Superordinate Theme 1: Finding Certainty Amidst Confusion**

### **2.4.1.1 Theme 1: Confusion**

#### **2.4.1.1.1      *Experiencing Confusion***

A theme in nearly all participants' narratives was the experience of confusion, often expressed in absolute or existential terms, as John describes:

*John: I didn't know what was happening... to me I found it almost impossible... to really exist... once I'd had the breakdown (p.2:10)*

As John's account suggests, these experiences of confusion typically coincided with acute episodes of illness, when mental illness had taken over participants' lives and had left them feeling bewildered. Participants frequently described questioning their identity and even the boundaries of reality at such times, as Megan described:

*Megan: so many thoughts bombarding each other and not really fully forming, voices, visual hallucinations, not knowing what was real and what wasn't (p.12:26)*

Such episodes were described by some participants as terrifying and highly isolating. For these participants in particular being acutely unwell had been a very disturbing experience, with long-lasting effects.

#### **2.4.1.1.2      *Faith Blurs Into Illness***

In addition to this general confusion almost all participants described confusing faith experiences and psychotic experiences, with the two seeming to ‘blur’ into each other. Again this occurred most often during acute psychotic episodes, as Helen describes:

*Interviewer: we’ve talked about the, the kind of maybe the physical world, the area of mental illness, the spiritual area of life and would you draw lines between those experiences?*

*Helen: Um, normally I would, when I’m well I would, yeah, but I think it kind of, it gets a bit blurred when [I’m] unwell. (p.24:29)*

Losing the ability to distinguish the spiritual from the psychotic often seemed to cause confusion beyond episodes of illness and sometimes left participants with unanswered questions for many years. This long-term confusion is apparent in Grace’s account of a confusion between faith and illness which began in her teenage years:

*Grace: those, episodes, which to me were faith episodes, have then become confused into becoming a psychotic belief really... and yet that was supposedly a faith experience because every time I heard God telling me to look up a verse I did it and to me that w- so then all of a sudden everything blurred and I didn’t know what was religio- uh religion until now, until last year – I didn’t know what was illness, (p.25:27)*

This is a rich and insightful excerpt which deserves closer inspection. While Grace claims that her confusion about the boundary between faith and illness has recently

been resolved, she does not sound convinced. Her hesitancy, the way she interrupts herself and her alternation between the past and present tenses all suggest that she remains unsure. Indeed she appears to be distracted by these issues as she speaks, suggesting that far from being resolved this uncertainty remains an ongoing source of anxiety for her, continuing to colour her experience of her faith and her psychosis.

For some participants this confusion was triggered or exacerbated by external factors, such as professionals, other Christians or the Bible, particularly when the guidance obtained from these sources seemed contradictory, as Megan found:

*Megan: On the one hand I've got people from church telling me that the Bible is the ultimate word of God, which I still believe it is. But then you've also got the people that are meant to be in charge of you, the people that are well, the people looking after you, telling you something completely different and you're not sure in your own head what's real and what isn't and then it's confusing and then it almost makes you doubt your faith and then you start feeling guilty because you're doubting things (p.14:6)*

Megan's description implies that the confusion she experienced between faith and illness related to a clash of cultures between Christianity and the mental health system. This cultural rift was implicitly apparent as a source of tension in most participants' accounts.

#### 2.4.1.1.3 Information Withheld



Another external factor which can be interpreted as causing confusion was the withholding of information by professionals. In particular participants described not being given their diagnosis and only finding it out later, sometimes by co-incidence.

*Carol: I sort of leaned-over and saw what was written in the notes and it was actually on the back of the card that they, that they give you, that the nurse – you get weighed and it, it got written on the back “has had psychosis” or “this is a psychotic patient” type –that word was mentioned on, on a, on a card for all and sundry to see – and that’s when I suddenly realised that the episode in hospital with my son was, was, was called “psychosis”, and that was the first time that that word was mentioned. (p.12:8)*

Carol’s account suggests a feeling of anger that such a momentous diagnosis had been withheld from her for some years and yet was readily shared between professionals.

#### **2.4.1.2 Theme 2: Finding Certainty**

In response to the confusion caused by episodes of psychosis and other mental health problems it was important for participants to regain a sense of certainty. Participants typically managed this in three ways: by distinguishing their faith from illness, by making sense of their experiences and by drawing on their faith as a source of certainty.

#### 2.4.1.2.1 *Distinguishing faith from Psychosis*

Participants felt that it was important to draw a distinction between their faith experiences and their psychotic experiences. For those participants whose psychotic experiences did not typically involve religious themes this distinction was easily made. As Alice said:

*Alice: quite often I've [been asked by professionals] "do you think it's God talking to you?" and I was like "well, not the language they use!" (p.28:16)*

However for those who had experienced religious delusions distinguishing between religious and psychotic experiences was more difficult. These participants were most likely to use strategies to distinguish faith from psychosis, such as drawing a distinction between the 'ill faith' of religious delusions and the real faith of spiritual experiences, or using logic to distinguish between faith and psychosis. A third strategy participants described was using external reference points such as ministers, friends, professionals or the Bible to help them to distinguish faith from psychosis. As Simon explains:

*Simon: I need to be around people who have got, who are Christians and mental health professionals because the one lot can say – the Christians can say "well actually that's got nothing to do with Christianity at all" and the other lot can say "well actually, [Simon], err you're ill." So the two combined are like a-another reference point that I use. ... It always helps to have other people around. (p.26:31)*

These attempts by participants to distinguish faith from psychosis can be interpreted as partly serving the purpose of asserting to others the authenticity of their faith as genuine rather than delusional. This is perhaps unsurprising given that participants were directly asked about this distinction by the interviewer. However, in finding ways to distinguish between faith and psychosis participants also seem to be managing doubt by establishing the validity of their spiritual experiences to themselves. This second function appears particularly important for those who have experienced religious delusions.

#### 2.4.1.2.2 *Sense Making*

Participants described two ways of making sense of their illness which seemed to reduce their sense of confusion by providing reassurance and a different perspective. Firstly participants tried to understand and rationalise their psychotic experiences, for instance by using medical or psychological accounts of psychosis which reframed psychosis as capable of being understood or explained. As Megan described:

*Megan: I'd heard the voices but I was still aware that you know, this was just some part of my subconscious, it can't actually hurt me – yes it can upset me but it can't actually hurt me, (p.7:3)*

However for Helen trying to understand her psychotic experiences was ineffective, leaving her with more questions than it answered. She found a second approach – spiritual acceptance - more helpful in making sense of her illness. This approach

was used by several participants and provided a different perspective, enabling them to come to terms with their illness and to see it as meaningful within Christian narratives. Helen found this an important coping strategy:

*Helen: she's given me quotes by Julian of Norwich that I hold on to, there's one that says "God did not say you'll not be tempest-tossed, but you'll not – never be overcome" and that's a great reassurance to me when I'm going through the mood swings because, you sort of think well, this is just a, a temporary disturbance and things will return to peace and um, calm and normality, it's just a frightening time or an upsetting time (p.18:9)*

#### 2.4.1.2.3 Faith as Anchor

For all but one participant faith itself had been a source of certainty, a consistent supportive element in their life amidst the uncertainty of illness. This sense of certainty and consistency is vividly captured by Simon's metaphor of faith as an anchor and a rock, which remains the same despite the changes in his mental health:

*Simon: God lives within me and he's like a rock inside of me, a constant, a rock, um, consistent ... and I feel like I've got someth- someone inside of me ... that is the anchor point er in me so that when I do get psychotic or depressed or manic he's a constant reference point to me of sanity and... stability (p.4:27)*

Participants described being able to trust in the certainty of their faith and feeling that their faith had protected them during their most vulnerable times, even preventing suicide. Consequently participants described their faith as an important part of their lives and for most participants faith was closely entwined with their identity. Alice's description illustrates how her faith had become central to her identity to the extent that she could not imagine herself without it:

*Alice: if they had a problem with my religion, it's not just my religion, they have a problem with me, because I don't think I can be separated from my faith, I'm a Mormon, but I'm also [Alice], but I'm [Alice] the Mormon.*  
(p.13:22)

However John's experience of faith had been different – he had felt unable to connect with it during times of illness and described feelings of ambivalence and uncertainty, seeing faith as something that seemed to work for other people, but not for him.

## **2.4.2 Superordinate Theme 2: Struggle for Acceptance and Personhood**

### **2.4.2.1 Theme 3: Feeling Devalued**

In contrast to the positive experience of faith as supportive during illness, participants described many of their interactions with others as unsupportive and devaluing, often exacerbating rather than alleviating feelings of confusion and isolation.

#### 2.4.2.1.1 *Unhelpful Attitudes*

Participants described often encountering attitudes towards faith or mental illness in other people that they found unhelpful. This occurred both in mental health services and in Christian contexts.

In mental health services participants described encountering two unhelpful attitudes. The first was a sense that professionals saw faith as irrelevant to treatment. Participants described professionals either avoiding, ignoring or never mentioning matters of faith during sessions. For Helen this attitude was diametrically opposed to her own view and left her feeling that something essential was missing from her treatment:

*Helen: I think they probably see it as something personal that's a category apart, that's got nothing to do with your mental health and I think it has everything to do with your mental health. (p.14:16)*

Secondly, most participants described professionals interpreting faith experiences as symptoms of illness - typically interpreting such experiences as religious delusions. Although two participants were angered by this, it was generally attributed to a lack of awareness and understanding of religious beliefs. Some participants empathised with the difficulty of distinguishing spiritual and psychotic experiences for professionals:

*Simon: If you don't have any personal faith at all, or an undefined faith, or maybe a different faith, you're going to have difficulty being able to separate-out what's psychiatric and what's faith. If you can't see that, that overlap and that differentiation then you could misinterpret symptoms, (p.25:4)*

Similarly participants also described encountering attitudes, beliefs and teachings relating to mental illness in the church which they found unhelpful. These beliefs included: psychosis being attributed to demon possession, illness being seen as a punishment from God, illness being seen as a lack of faith, a belief that Christians should not get depressed, a belief that Christians should rely upon God and therefore should not need treatment and an assumption that mental illness would be healed by prayer. Such beliefs were seen as being held by individuals or particular churches rather than being universal in the church, although participants often described encountering them in conversations with church leaders. Carol's experience of encountering one such belief communicated in a sermon resulted in her experiencing feelings of inadequacy in herself as a Christian and as a person:

*Carol: I was on anti-depressants and I actually remember the preacher talking about anti-depressants, and saying, you know, society these days want to fix everything with an anti-depressant and almost saying it wasn't good and they should have God in their life and they wouldn't need anti-depressants, and I remember thinking, I- made me feel even worse about myself and I'm thinking "I am, I am actually on anti-depressants" and my, my self-esteem felt very low with what he'd said (p.25:2)*

The belief that psychosis indicated that a person was possessed by demons was the only one of these beliefs which was recurrent in the accounts of half of the sample. This subject evoked strong feelings in participants, among whom opinion was divided, with two participants having believed themselves to be demon possessed at some point and two participants disbelieving the existence of demon possession. Participants' accounts of this issue and the researcher's own experiences suggest that this issue is also divisive in the wider church, with opinion divided amongst both congregations and church leaders. However, despite their differences of opinion all four participants reported that the church's handling of this issue had at times been harmful to them or others.

For Grace, concerns that her psychosis indicated demon possession had been particularly problematic over many years and the difference of opinion she encountered between ministers seems only to have added to her confusion:

*Grace: I had lots of voices in my head shouting at me ... I thought that must be it, I must be possessed, so I went to the church and I found a minister who agreed to say that I was possessed and then prayed with me and supposedly released me from all these demons, lots and lots of them, and the other minister at the church found out and went absolutely ballistic about it and was really apologetic to my mum or to someone, he was really angry about it anyway when he found out what had been going on. And um, then since then I went to my minister in... the last church that I've been to and he said "well people who are Christians can't be possessed" (p.10:20)*

She went on to say:



*Grace: I felt I'd been listened to by the first one, but the second one yet again, just like everybody else I've come across dismissed it as a, stupid thing, I don't need someone to say "yes" or "no that you're not", I just would like at some point in my life that somebody would have a discussion with me about it, (p12:19)*

In the second extract Grace makes it clear that her frustration about this issue relates to the way ministers responded to her rather than the actual answers they had given. Ministers may have avoided lengthy discussion of this issue, feeling ill-equipped to give a definitive answer. However they appear not to have perceived her unspoken request to acknowledge and empathise with her struggle to differentiate faith from illness. Consequently Grace felt that her needs had been ignored and that she had not been taken seriously as a person.

#### **2.4.2.1.2      Prejudice**

Participants' accounts of feeling devalued by others frequently extended beyond encountering unhelpful attitudes to feeling that they were the subject of prejudice. Again this experience was equally prevalent in the church and in mental health services, although taking different forms.

In church most participants described feeling that there was a considerable stigma attached to mental illness. As Megan describes:

*Megan: I just think there's still a lot of taboo about mental illness in, certainly in the church as a whole, not necessarily specific churches but overall there's still a big taboo about mental illness, and even in general society there's a lot of people that just don't understand it (p.4:18)*

This extract captures several themes also expressed by other participants. Firstly Megan's description of mental illness as taboo implies that it is a subject that is unacceptable, not spoken about and carries a sense of exclusion, as indeed had been her experience in one church. Secondly Megan highlights that the stigma of mental health in church is at once a reflection of stigma in wider society and yet also a particular problem for the church. This was also present in the accounts of other participants who described stigma arising from particular narratives in some churches, such as the belief that Christians should not be depressed. However, as Megan notes, this stigma of mental illness is not universal within the church and she, like several other participants, also described experiences of her mental illness being accepted in church.

In mental health services participants described encountering prejudice when professionals introduced their own personal beliefs into sessions, challenging or dismissing client's own beliefs. Detailed personal accounts of such encounters were given by half of the sample and in all cases participants reported strong feelings of anger, indignation and personal offense. It was clear that although participants wished to be able to discuss their own spiritual beliefs with professionals, it was considered highly unprofessional for professionals to challenge their religious beliefs, as Alice describes:

*Alice: I did say to him "you've changed your attitude since last week" and he went "well I found that you were a Mormon" and I said "well..." I said "what do you mean?" and he said ... "you can't talk to you people, your head's full of rubbish" and I thought 'how insulting and unprofessional' and he sort of said "I don't think there's any point continuing this" and I said "yeah, but" I said "but if I'd come in and I'd said to you last week 'oh I'm a Muslim' and this week I'd worn a head scarf would you be like that to me?" and he went "it's completely different"... I said "well it's not, it's my faith and you're cheapening it by saying that I'm one of 'those people', so you're lumping me into, you're just rubbishing every single thing that I say", and he said "yeah but since I found out that you know, you go to that kind of church, ... I just don't think that there's any point talking to you because I just don't think that you're going to be open to everything" and I said "well you know" I said "since I found out that you're an idiot I just decided that I'm not going to stay in your sessions" and I left. (p.11:4)*

As this extract illustrates, the centrality of Alice's faith to her identity meant that a psychologist dismissing her faith was experienced as a very personal attack, threatening her sense of self and destroying any confidence she previously had in her therapist. Although Alice's experience appears extreme it is representative of incidents with professionals reported by several participants. However, not all interactions in which professionals disclosed their personal beliefs were destructive; where participants encountered professionals who disclosed having the same religious beliefs as them they typically reported positive experiences.

#### 2.4.2.1.3 *The Dilemma of Self-Disclosure*

As the previous sections have shown, participants often found that self-disclosing by talking to professionals about faith or by talking to Christians about mental illness resulted in interactions which left them feeling worse – devalued rather than supported. As a result of such experiences many participants spoke about deliberately choosing whether to self-disclose, or whether it would be unhelpful to do so. Some participants felt apprehensive about self-disclosure, fearing the reaction that they would receive, others felt disillusioned and had given-up disclosing information about their faith or their illness feeling that this was the easier option. Still others described ‘setting out their stall’ by self-disclosing early in their contact with professionals as a litmus test of whether they would be accepted and thus whether they should invest in the relationship.

Toby’s account demonstrates this dilemma. He described initially speaking to professionals about his faith but after discovering that his beliefs were being seen as psychotic and resulting in additional diagnoses he became wary of self-disclosure. He feels that belonging to a non-mainstream Christian group made it more likely that professionals would pathologise his spiritual experiences:

*Toby: Psychiatrically when you’re talking like that then you’ve got psychosis and you’ve got um paranoia, so you learn not to speak about it, so you’re very careful when you’re talking to a psychiatrist or a consultant, ‘cos what they write down with their ink, um, it’s not about spirituality, it’s about “he*

*believes in things that don't exist, he hears things, he sees things that aren't there", so it's harder if you mention that you're a spiritualist. (p.3:28)*

#### **2.4.2.2 Theme 4: Regaining Personhood**

In the first two themes of this analysis participants described the loss of their sense of self and reality through mental illness and their personal attempts to regain a sense of certainty and stability. In the third theme participants' accounts indicated that their identity and sense of self-worth had also been threatened by their interactions with mental health professionals and other Christians which left them feeling devalued and isolated. The analysis now turns to consider participants' experiences of regaining a sense of identity and personhood through their interactions with others. There are three ways in which participants achieved greater personhood: firstly by being treated as a person rather than an object, secondly by receiving spiritual care and thirdly by finding a spiritual home.

##### **2.4.2.2.1 Being Treated As a Person**

A common theme in participants' narratives was the ineffectiveness of psychiatric treatment, particularly medication. Relatedly participants described dissatisfaction with their treatment, feeling that when treatment consisted primarily of medication it was inadequate. There was a sense in participants' accounts that when

treatment was solely focussed on medication and risk management through hospitalisation they were being treated as less than human – like an object or an animal. This is implied in John’s choice of metaphor:

*John: [my psychiatrist] wasn’t particularly communicative so, that was it, he didn’t do me any good at all, except push pills down me throat. (p.15:18)*

By contrast, in describing good experiences of care and support participants regularly described being treated as a person. They cited simple acts of humanity - such as being listened to, or others having time for them - as the difference between such good experiences and other experiences of care and support. Likewise some participants spoke of the importance of care being holistic, again emphasising the concept of being treated as a whole person rather than being defined by their illness. As Simon describes:

*Simon: for about eight years I was treated by a [psychiatrist] ... who uh, treated me as a human being rather than a walking illness (p.11:15)*

Drawing together these strands it appears that participants generally found personal, supportive aspects of care more valuable than the curative elements of care. Thus, as Grace described in her earlier account of speaking to ministers about demon possession, participants may often feel that their most important needs are not considered. Perhaps then, in describing psychiatric treatment as ineffective or inadequate participants are actually communicating that they want a different kind of care. That unless they feel respected as a person, care is not valuable to them. Given the recurrence and chronicity of psychotic disorders it is perhaps unsurprising

that participants would value the supportiveness of care over its effectiveness in reducing symptoms.

#### *2.4.2.2.2 Spiritual Care*

Since faith played an important part in almost all participants' lives and was a central part of the identity of most, participants felt it was essential that they should be able to discuss matters of faith as part of psychiatric care. Thus being treated as a whole person required the presence of spiritual care. There were three recurring themes in participants' descriptions of spiritual care, namely that spiritual assessment should be standard, professionals should be open to discuss matters of faith and chaplaincy care should be more readily available in psychiatric hospitals.

The majority of participants reported that they had never had their spiritual needs assessed and almost all expressed feelings that spiritual assessment was important or desirable for them. Perhaps unsurprisingly, given the rarity of spiritual assessment, only one participant described having seen a chaplain regularly while hospitalised, although most had encountered chaplains at some point. Participants typically felt that chaplaincy provision was insufficient, with Megan describing staying on a ward that the chaplain visited for only one hour per month.

As implied by the previous theme, participants were often disappointed by the lack of openness shown by professionals towards discussing matters of faith. Indeed the majority of participants described experiences of professionals not being prepared to discuss spirituality with them. However where professionals showed a

willingness to allow participants to discuss their faith participants described such care as very valuable, consistently representing their best experiences of care.

This feeling that the best care is spiritually sensitive came across clearly in Toby's account. His first experience of encountering professionals who were proactive in assessing and discussing his spiritual needs was a profound moment for him, representing a turning point in his experience of care and triggering a return to faith. Whereas he felt that psychiatric treatment had previously inhibited his faith, for the first time it was supporting spiritual growth and enabling him to access support from his church.

*Toby: I find the spiritual bit's never brought in and the first time that was brought into my treatment was six years ago... I was allowed to talk about it, because ... they actually came at me with that approach... The holistic approach, and um it became quite evident that a part of my life that was missing and had been missing was the spiritual part, then when I mentioned that I was a Spiritualist I got a completely different reaction: "well why haven't you been back to church?" I says "well I've lost me faith" um and that was down to the way I've been treated by psychiatrists and consultants as well, and the man says "we need to work on that" and I couldn't believe that for the first time it was like allowed to be a Spiritualist and be accepted, um and that was the first time in my mental health treatment that it became part of my treatment plan and that I was encouraged to go to my local church and to mix. (p.31:12)*



#### 2.4.2.2.3 *Finding a Spiritual Home*

Participants also regained a sense of personhood through finding acceptance and belonging in Christian community. However, it often took participants time to find a Christian community in which they felt accepted, frequently due to negative experiences of stigma or unhelpful attitudes within the church. For instance Carol's experience of hearing a sermon about Christians not needing anti-depressants, cited earlier, precipitated her leaving that church. Participants described searching for a church in which they belonged and sometimes this involved trying many different churches.

Another reason that participants changed churches was illness. Participants often described being away from church for long periods of time as a result of illness, particularly when hospitalised. While some participants tried to maintain contact with church, others lost their faith at such times. Given these absences from church, it is unsurprising that some participants described appreciating Christian friendships that were independent of church. Nevertheless there was something very important about belonging to an accepting, supportive church community and returning to church after being unwell often carried a sense of 'coming home'. For Carol this was a wonderful experience:

*Carol: there was one lady I met in hospital who was a Christian - actively a Christian and she did try to talk to me about my beliefs and I just said "well yeah, I was brought up, and I do understand, and I do want..." but at that particular time I was in hospital I'd got – I really just thought no, ... very confused about my religion, um and she was very kind to me and kept*

*talking to me and got a Bible and said “well you know, God hasn’t forgotten you” ... I felt quite safe with her because I thought... I like her and she... it’s almost like going back to my childhood, you know – somebody that’s, you know, is, is very committed ... and when I came out of hospital I started to see her socially and she took me to her church ...so I went to quite a few churches at that particular time after I came out of hospital to try and ... renew my belief and it was nice at the time ‘cos it was almost – I felt like being a child again, you know, it was like familiar to how I would have been brought-up (p.23:3)*

Her description of reconnecting with Christians and the church as like ‘being a child again’ profoundly expresses the sense of belonging and security associated with a home. This account also illustrates the processes of being away from church during illness, losing faith, finding Christian friendship, searching for churches and returning to church.

Interestingly, for both Alice and Toby the search for acceptance and belonging led them beyond mainstream churches to more fringe groups, respectively becoming a Mormon and a Spiritualist. They described these fringe groups as profoundly welcoming and accepting - categorically different from their previous experiences of mainstream denominations. It is worth noting that both Mormonism and Spiritualism are often not accepted or recognised as Christian by mainstream denominations. It therefore seems likely that having not felt accepted in mainstream churches these participants felt they could relate to the outsider status of these groups. Likewise members of these groups may have been more willing to

welcome Christians with psychosis, having been seen as outsiders themselves.

Toby alludes to the outsider status of Spiritualists in noting their more liberal interpretation of the Bible:

*Toby: it was amazing, it was like I've been searching for years and years... to suddenly find a religion that's accepting, accepts not only me as a homosexual, but other people that maybe don't conform to what the Bible says word for word, um and to meet these lovely people... it was almost like, oh how can I describe it? Having this love all the time, and not meant to be having this love 'cos I couldn't be a Christian, 'cos I was gay, it was almost like there was two halves of my heart. When I went to the [spiritualist church] the other half came and that was the spiritual part (p.29:12)*

Toby's account also illustrates the powerful potential for Christian community to help participants to regain a sense of personhood. His metaphor of the two halves of his heart indicates that joining the spiritualist church enabled him to integrate his spirituality with the rest of himself, including his sexuality. As a result he felt like whole person for the first time.

## **2.5 Discussion**

This study sought to explore the experience of Christians with psychosis, considering their understanding of the relationship between faith and psychosis and their experiences of mental health treatment.

Due to the diversity of beliefs and practices within Christianity and the idiosyncratic nature of psychosis it was anticipated that there would be considerable variation between the experiences reported by participants in this study. The use of IPA in this study was well suited to such varied experiences, enabling the analysis to explore both the common themes shared between participants and the 'texture' (Smith, Flowers, & Larkin, 2009, p. 200) of individual experience within the sample. In addition, the interpretative approach taken in IPA enabled this study to look beyond what was ostensibly communicated to consider the deeper impact of psychosis and treatment upon identity and personhood.

In what follows the main findings will be related to the research questions and then discussed in relation to existing literature. Consideration will then be given to the limitations of this study, after which suggested implications for practice and future research will be outlined.

### **2.5.1 Exploration of Themes**

#### ***2.5.1.1 Relation of findings to research questions***

IPA produced two superordinate themes. The first of these themes 'Finding Certainty Amidst Confusion' primarily relates to the first research question as it incorporates participants' understandings of the relationship between faith and illness. The second superordinate theme 'Struggle for Acceptance and Personhood' relates more closely to the second research question, incorporating participants' experiences of mental health treatment.

### ***2.5.1.2 Superordinate Theme 1: Finding Certainty Amidst Confusion***

The first superordinate theme encapsulates a central conflict for participants between the profound confusion caused by psychosis and their attempts to re-establish a sense of stability and certainty. Participants experienced the onset of illness as deeply disruptive, often threatening their understanding of themselves and of reality, an experience Sullivan (2009) terms 'existential anxiety'. This search to find certainty amidst confusion closely resembles the search for "meaning in 'madness'" which was the central process identified by Macmin and Foskett's grounded theory analysis of participants' experiences (2004, p. 33).

This study found that for Christians with psychosis the confusion caused by psychotic illness had an additional layer of complexity caused by the blurring of faith experiences into experiences of psychosis. This appeared particularly problematic for participants who had experienced religious delusions, potentially having a significant long-term detrimental impact on both faith and illness. Similar experiences were reported in Drinnan and Lavender's study (2006), in which most participants with religious delusions experienced uncertainty as to whether experiences were spiritual in nature.

Although faith contributed to the confusion experienced by Christians with psychosis, this study found that it was also a very important resource for participants in coping with mental illness. Participants variously described their faith as providing certainty, stability, reassurance and a positive identity, enabling

them to cope with the ravages of psychotic episodes and periods of hospitalisation. This mirrors the findings of previous studies of the experience of service users with spiritual beliefs (Drinnan & Lavender, 2006; Macmin & Foskett, 2004; Smith & Suto, 2012).

### ***2.5.1.3 Superordinate Theme 2: Struggle for Acceptance and Personhood***

The second superordinate theme identifies another central conflict for participants: the struggle to find acceptance and personhood when interactions with others often result in feeling devalued and isolated. This struggle can be seen as mirroring the intrapersonal conflict between confusion and certainty in interpersonal interactions. Devaluing interactions with others contribute to a sense of confusion whereas finding acceptance and personhood are additional ways of re-establishing a sense of certainty.

#### ***2.5.1.3.1 Double Bind of Isolation***

Participants' accounts suggest that when they found acceptance at church or with mental health professionals, this could have a transformative effect on both their wellbeing and their faith. Yet more often this group of participants struggled to find acceptance from others. The experiences participants reported suggest that Christians with psychosis may often experience a double-bind of alienation in which their psychotic illness is experienced as unacceptable at church and their faith is

experienced as unacceptable in mental health services. This double bind was also apparent in the experiences of the predominantly Christian sample in Macmin and Foskett's study (2004) and had a similar effect, causing alienation and threatening their sense of humanity. Taken together with Macmin and Foskett's findings the present study suggests that Christians with mental health problems are a marginalised group experiencing significant isolation. Given the stigma surrounding psychosis in society this issue may be particularly problematic for Christians with psychosis.

#### *2.5.1.3.2 Spiritually Sensitive Care*

A key finding of this study is the importance of faith being recognised and supported within psychiatric treatment for Christians with psychosis. Participants' narratives suggest that being able to talk about their faith was central to being treated as a person. Conversely not recognising a person's faith was perceived as not recognising them as a whole person and frequently resulted in disengagement from services. The importance of supporting service users to talk about their spiritual needs as part of treatment was also a finding of Macmin and Foskett's study (2004).

#### *2.5.1.3.3 Dismissing Beliefs*

Many participants described feeling that professionals pathologise spiritual experiences as psychotic and may also dismiss spirituality as irrelevant to care. Some participants described feeling that professionals dismissed their spiritual beliefs outright, causing strong feelings of disbelief, anger and personal offense. Incidents of professionals dismissing or pathologising spirituality have been reported by participants in previous studies (Drinnan & Lavender, 2006; Macmin & Foscett, 2004; Mental Health Foundation, 2002). The present study suggests that this problem may not have improved in recent years. However some of the incidents described by participants in the present study were historical.

Previous research has suggested that frequent exposure to religious delusions and psychiatric working culture may predispose mental health professionals to pathologise spiritual experiences (Eeles et al., 2003; Neeleman & Persaud, 1995). Yet in the present study participants more often attributed the pathologising or dismissing of their faith to professionals' own spiritual beliefs. Such incidents suggest that for some professionals clients' religious beliefs may stir-up strong negative counter-transferential feelings (Neeleman & Persaud, 1995), leading to lapses in professionalism as their personal feelings are expressed.

#### *2.5.1.3.4 Response of The Church*

Finally this study highlights the significance of the church's response to psychosis and mental illness in general. When sensitive, accepting and supportive, church could play a central role in enabling participants to regain a sense of personhood



amidst chronic and ongoing psychological distress, acting like a spiritual 'home'. However participants reported frequently encountering a combination of stigma and attitudes they found unhelpful in church, some of which had arisen from narratives within the church. While the nature of psychotic illness might suggest that some of these perceived attitudes could have resulted from paranoia, the level of detail and consistency of the incidents participants described suggests otherwise. Moreover such narratives were recognised as contributing to harmful experiences of church in the Somerset studies (Macmin & Foskett, 2004; Mental Health Foundation, 2002). The potential for churches and other spiritual groups to either support recovery or to cause harm has also been recognised in other studies (Drinnan & Lavender, 2006; Sullivan, 2009).

The present study identified several narratives that may contribute to stigma for Christians with mental illness. In particular the thorny issue of demon possession appears particularly problematic for Christians with psychosis. It would appear that psychotic symptoms such as auditory hallucinations may be interpreted as evidence of demonic possession by some Christians and church groups. Understandably such interpretations are deeply disturbing for the individual concerned.

### **2.5.2 Limitations**

This study included several specific questions within the interview schedule relating to the confusion of faith and psychosis by professionals. It was considered important to include these questions as they were central to the rationale for

conducting this study and built upon the findings of previous research (e.g. Drinnan & Lavender, 2006; Macmin & Foskett, 2004). Nevertheless, these questions may have led participants away from expressing their own opinions in their own terms (King & Horrocks, 2010; Smith & Osborn, 2008). This possibility was carefully considered during the analysis process.

The choice to recruit participants via mental health charities and service user organisations may also have influenced the findings of this study. This approach could have disproportionately recruited 'activist service users', whose experiences of treatment might have motivated them to become engaged in shaping services. This is suggested by the fact that several participants were involved in work within mental health.

While the majority of participants in this study had been treated for psychosis during the last year, participants typically had long histories of psychiatric treatment, with an average of 18 years since their first inpatient admission. Thus, although many of the experiences participants reported had occurred in the past five years, others were more historic. Consequently this study provides limited evidence to determine whether spiritually-sensitive care is becoming more commonplace within the mental health system.

### **2.5.3 Implications**

#### ***2.5.3.1 Implications for Practice***

Although it is not possible to generalise from the small number of service users sampled in this study, there was considerable overlap between the findings of this study and previous qualitative studies of service users with spiritual beliefs. Cumulatively these studies provide initial evidence of areas of service provision deserving attention.

Firstly it is important that mental health professionals allow service users with spiritual beliefs to talk about their spirituality within treatment. Spiritual assessment is an important means of incorporating spirituality into treatment and may enable spirituality to be harnessed to support recovery and prevent relapse.

Incidents reported by participants suggest limited awareness of spiritual needs and practices among mental health professionals, sometimes resulting in unprofessional conduct. This indicates a need for staff training to support professionals in understanding and responding appropriately to patients' spiritual beliefs.

This study and previous studies recruiting predominantly Christian samples also highlight a need for change in the church's response to mental illness, particularly regarding psychosis. Participants' accounts suggest a need for greater dialogue about mental health in some church groups, particularly around narratives within the church that equate mental illness with sinfulness or evil. Such changes could be facilitated by the provision of mental health awareness training for church leaders.

#### ***2.5.3.2 Future Research***

There was considerable overlap between the findings of this study and previous qualitative studies of service users with spiritual beliefs. Since the capacity to generalise from qualitative research is limited it would be beneficial for larger-scale quantitative research to test these findings in order to inform service improvements.

#### **2.5.4 Conclusion**

This study has investigated the experience of eight Christians with psychosis using semi-structured interviews and IPA. Participants' accounts suggest that Christians with psychosis face two concurrent challenges: a struggle to find certainty amidst confusion and a struggle to achieve personhood when interactions with church and mental health services often leave them feeling devalued. These findings provide initial evidence that Christians with psychosis may be a particularly marginalised group, experiencing isolation both at church and in mental health services.

## References:

- Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in clinical psychology an introduction for students and practitioners*. Hoboken, N.J.: J. Wiley.
- Borras, L., Mohr, S., Brandt, P. Y., Gilliéron, C., Eytan, A., & Huguelet, P. (2007). Religious beliefs in schizophrenia: Their relevance for adherence to treatment. *Schizophrenia Bulletin*, 33(5), 1238-1246. doi: <http://dx.doi.org/10.1093/schbul/sbl070>
- Clarke, I. C. (2001). Introduction. In I. C. Clarke (Ed.), *Psychosis and Spirituality : Exploring The New Frontier*. London; Philadelphia: Whurr Publishers.
- Cornah, D. M. H. F. (2006). *The impact of spirituality on mental health : a review of the literature*. London: Mental Health Foundation.
- Drinnan, A., & Lavender, T. (2006). Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions. *Mental Health, Religion & Culture*, 9(4), 317-331. doi: <http://dx.doi.org/10.1080/13694670500071711>
- Eeles, J., Lowe, T., & Wellman, N. (2003). Spirituality or psychosis? - An exploration of the criteria that nurses use to evaluate spiritual-type experiences reported by patients. *International Journal of Nursing Studies*, 40(2), 197-206.
- Forchuk, C., Jewell, J., Tweedell, D., & Steinnagel, L. (2003). Reconnecting: the client experience of recovery from psychosis. *Perspectives in psychiatric care*, 39(4), 141-150.
- Gearing, R. E., Alonzo, D., Smolak, A., McHugh, K., Harmon, S., & Baldwin, S. (2011). Association of religion with delusions and hallucinations in the context of schizophrenia: Implications for engagement and adherence. *Schizophrenia Research*, 126(1-3), 150-163. doi: <http://dx.doi.org/10.1016/j.schres.2010.11.005>
- Getz, G. E., Fleck, D. E., & Strakowski, S. M. (2001). Frequency and severity of religious delusions in Christian patients with psychosis. *Psychiatry Research*, 103(1), 87-91. doi: [http://dx.doi.org/10.1016/S0165-1781\(01\)00262-1](http://dx.doi.org/10.1016/S0165-1781(01)00262-1)
- Hunt, H. T. (2007). "Dark nights of the soul": Phenomenology and neurocognition of spiritual suffering in mysticism and psychosis. *Review of General Psychology*, 11(3), 209-234. doi: 10.1037/1089-2680.11.3.209
- King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. Los Angeles: SAGE.
- Macmin, L., & Foskett, J. (2004). "Don't be afraid to tell." The spiritual and religious experience of mental health service users in Somerset. *Mental Health, Religion and Culture*, 7(1), 23-40.
- Mental Health Foundation. (1997). *Knowing Our Own Minds*. London: Mental Health Foundation.
- Mental Health Foundation. (2002). *Taken Seriously: The Somerset Spirituality Project*. London: Mental Health Foundation.
- Morgan, G. (2010). Independent advocacy and the "rise of spirituality": Views from advocates, service users and chaplains. *Mental Health, Religion & Culture*, 13(6), 625-636. doi: <http://dx.doi.org/10.1080/13674676.2010.488435>

- Neeleman, J., & Persaud, R. (1995). Why do psychiatrists neglect religion? *British Journal of Medical Psychology*, 68(2), 169-178.
- O'Connor, S., & Vandenberg, B. (2010). Differentiating psychosis and faith: The role of social norms and religious fundamentalism. *Mental Health, Religion & Culture*, 13(2), 171-186. doi: <http://dx.doi.org/10.1080/13674670903277984>
- Phillips, J. K. (2009). *The experience of hope in those diagnosed with schizophrenia: A qualitative study*. (AAI3338144). Retrieved from <http://gradworks.umi.com/33/38/3338144.html>
- Pouchly, C. A. (2012). A narrative review: Arguments for a collaborative approach in mental health between traditional healers and clinicians regarding spiritual beliefs. *Mental Health, Religion & Culture*, 15(1), 65-85. doi: <http://dx.doi.org/10.1080/13674676.2011.553716>
- Rashd, M. A. (2010). Religious experience and psychiatry: Analysis of the conflict and proposal for a way forward. *Philosophy, Psychiatry, & Psychology*, 17(3), 185-204.
- Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5(1), 9-27. doi: <http://dx.doi.org/10.1080/17437199.2010.510659>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis : theory, method and research*. Los Angeles: SAGE.
- Smith, J. A., & Osborn, M. (2008). Interpretive Phenomenological Analysis. In J. A. Smith (Ed.), *Qualitative psychology : a practical guide to research methods*. Los Angeles, CA: SAGE Publications.
- Smith, S., & Suto, M. J. (2012). Religious and/or spiritual practices: Extending spiritual freedom to people with schizophrenia. *Canadian Journal of Occupational Therapy*, 79(2), 77-85.
- Spirituality Forum. (2011). A report on the place of spirituality in mental health 2011: Spirituality Forum.
- Stifler, K., Greer, J., Sneek, W., & Dovenmuehle, R. (1993). An Empirical Investigation of the Discriminability of Reported Mystical Experiences among Religious Contemplatives, Psychotic Inpatients, and Normal Adults. *Journal for the Scientific Study of Religion*, 32(4), 366-372.
- Suhail, K., & Ghauri, S. (2010). Phenomenology of delusions and hallucinations in Schizophrenia by religious convictions. *Mental Health, Religion & Culture*, 13(3), 245-259. doi: <http://dx.doi.org/10.1080/13674670903313722>
- Sullivan, W. P. (2009). Spirituality: A road to mental health or mental illness. *Journal of Religion and Spirituality in Social Work*, 28(1-2), 84-98.
- Swinton, J. (2007). Foreword. In M. E. Coyte, P. Gilbert & V. Nicholls (Eds.), *Spirituality, Values and Mental Health: Jewels for The Journey*. London; Philadelphia: Jessica Kingsley Publishers.
- Tarko, M. A. (2003). *A grounded theory study of the experience of spirituality among persons living with schizophrenia*. (AAINQ73252). Retrieved from <https://circle.ubc.ca/handle/2429/13237>
- Tepper, L., Rogers, S. A., Coleman, E. M., & Malony, H. N. (2001). The prevalence of religious coping among persons with persistent mental illness. *Psychiatric Services*, 52(5), 660-665. doi: <http://dx.doi.org/10.1176/appi.ps.52.5.660>

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15(2), 215-228. doi: <http://dx.doi.org/10.1080/08870440008400302>

## **Chapter 3: Reflective Paper**

### **All of The Parts of Me: Managing Roles During Clinical Training**

Word count (excluding quotations and reference list): 3295



### **3.1 Introduction**

Shortly after starting clinical training I made a friend at church who told me that he had a diagnosis of schizophrenia and had been treated on psychiatric wards. He told me that when he spoke to mental health professionals about his faith they treated it as evidence of his illness. Later that year he was sectioned again. As I visited him in hospital I wondered whether the way he talked about his faith to professionals was resulting in a prolonged admission. I wondered whether other Christians with psychosis, like him, also felt that their faith was pathologised as mental illness. It was this experience that inspired my empirical study (Chapter 2).

Visiting my friend on the psychiatric inpatient ward I became aware of various roles within me: I was a Trainee Psychologist but I was also a member of the public – a visitor, I was a friend and I was a Christian. Hearing my friend talking about his faith in this context made me aware of tensions between these roles. In this paper I will reflect on the process of managing these different roles with my friend, during training and through the research process. In doing so I will consider the ways in which my new role of Clinical Psychologist - situated within a wider mental health system - has interacted with my existing roles.

To preserve anonymity I will refer to my friend with the pseudonym 'Tom' throughout this paper. Research participants (from the empirical paper, Chapter 2) will be referred to by the pseudonyms used in the empirical paper.

### **3.2 Distinguishing Faith from Illness**

As I got to know Tom I found it difficult to know whether he was mentally ill. His conversation was dominated by matters of faith in much the same way as one of my research participants later described:

*Simon: but you see when I was psychotic with religious delusions ... I got sort of God and Jesus on the brain, so, ...I couldn't get away from it really*

As a psychologist, Tom seemed unwell to me, but as a Christian I was reluctant to treat what was expressed as faith as being illness. Moreover, as a fellow Christian I knew that almost all of what he said had a basis in the Bible, which I found confusing. Here the authority of the Bible and my faith was clashing with the authority of my profession.

At some point shortly prior to his admission Tom entered a state of crisis, an experience he referred to as “survival mode”. By this stage when he was neglecting to care for himself properly I felt sure that he was unwell. However, I found it very difficult to identify a particular point at which he had become unwell. Reflecting now it is interesting to note that this question was important to me at the time – is this perhaps a sign of having internalised a ‘medical model’ of mental illness (Boyle, 1999) in which a clear distinction is drawn between madness and wellness? As recent calls from within Psychology have highlighted, such a model is highly contentious (Bentall, 2004; British Psychological Society, 2012).

One problem with identifying whether Tom was unwell was that Tom remained himself. In illness he was much the same person, only exaggerated: his already charismatic personality became brash and his beliefs even more absolute. This

contained a strange paradox: in one sense he was not well and yet in another sense he was more alive – more full of life, energy, passion – than ever. In fact the time he was least ‘alive’ seemed to be when he had been sedated with high doses of psychiatric medication. This sense of psychotic illness exaggerating existing personality was recognised by some of my participants also. As Simon described:

*Simon: I had a... manic psychotic episode and I became a ‘Manic Street Preacher’ to quote the band ... it exaggerated what I believe anyway – just exaggerated it and I would button-hole everybody on that high street and and start engaging them in conversations about faith and about Jesus, um which I wouldn’t normally do.*

Somehow the idea that psychosis only exaggerates an individual’s personality was surprising to me. In reflecting on this subject I realised that I had unconsciously categorised psychotic illness as entirely ‘other’ – just as distinct from normality as dreaming and waking. This is almost certainly a product of societal narratives about madness, which Bentall (2004) suggests have been used to keep madness at a safe distance, sparing us from confronting it.

Meeting Tom and my participants challenged my assumptions about psychosis. My participants were not categorically different. In fact, as fellow Christians they seemed much like me. This personalised the research for me – my participants’ experiences could as easily have been my experience.

Looking back at the end of the research process it is interesting to recognise that in trying to distinguish between Tom’s faith and his illness I had experienced some of

the confusion that my participants described in distinguishing their faith from their illness.

### **3.3 Clash of Cultures**

#### ***3.3.1 Approach to Risk***

Another tension between my different roles became apparent as a clash of cultures between my Christian faith and the mental health system within which I was working as a Trainee Psychologist. I first noticed this when visiting Tom in hospital. Speaking to a psychiatric nurse several weeks into his stay I asked why Tom was still being detained. The answer I received focused around managing risk, but the nurse avoided giving any specifics as to the nature of this risk. Perhaps Tom seemed unpredictable and therefore risky? Perhaps, just as I had found it hard to identify exactly what made Tom ill, these professionals sensed risk but struggled to specify exactly what it was? I sensed a culture of risk aversion in the mental health system (Andersson & Liff, 2012). By contrast my faith seemed more characterised by what the mental health system might term “positive risk taking.” I was reminded of a lyric from the song “I want more – part 2” (Faithless, 2004) which seemed to encapsulate the tension between the Christian and Psychiatric perspectives:

*I want more... decisions based upon faith and not fear*

#### ***3.3.2 Internalising Culture***

At the same time I noticed the culture of the mental health system in myself. At times I was fearful of Tom's zeal and fervour. Like those caring for him sometimes I wanted him to calm down so that he would be less agitated, but was I just intolerant of his personality and his beliefs? I wasn't sure that the mental health system was helping Tom and I feared I was becoming part of that system. This clash is apparent in one of my entries in my reflective journal in which I consider the professional issue of boundaries in my friendship with Tom:

*[Tom] again contacted me the other day... asking whether he could live with [my wife] and I, I replied to reiterate that he was welcome for a day or two, but not to stay long term. Again I struggle with a feeling that on the one hand my faith would suggest we give sacrificially [selflessly]... whereas my profession would advocate self-care, caution, distance... I hear in my own thoughts fear and I'm reminded of how fear is keeping [Tom] medicated and on a section. Fear is the driving force in so many mental health decisions – fear of risk. And that reminds me of my faith and my identity as a Christian – as being a person who does not have the same fear that our society has, who lives by faith, by hope.*

When interviewing participants for my research I again became aware of this clash of cultures in two ways. Firstly my participants described wanting to talk about their faith as part of mental health treatment but not being asked about their spiritual beliefs by professionals. I realised that despite being in the midst of conducting research on this subject I rarely asked my own clients about their spiritual beliefs in my clinical work. Again this caused me to feel that I had become

‘part of the system’, acculturated to its norms which contradicted my personal belief in the importance of considering spiritual needs.

The second way in which a clash of cultures was apparent in my research was in my participants’ perceptions of me. As a Trainee Psychologist I was aware that participants might perceive me as part of the mental health system, which might lead them to feel wary of telling me about their experiences. I sensed this particularly when speaking to a group of service users about my research at a charity-run drop-in. Having come directly from work I was still wearing my work clothes and I sensed this created a power dynamic between me and the service users. One of them in particular seemed wary, saying “why should I talk to you? I don’t know you from Adam.” Had I emphasised my role of student over professional, as advised by King and Horrocks (2010) I might not have incurred this reaction.

### ***3.3.3 Competing or Compatible Cultures?***

My friendship with Tom also made me question my own faith and wonder whether I was committed enough. Tom read the Bible and was trying to follow it word for word, he took its commands to tell others about his faith literally and told everyone, including his psychiatrists, whereas I felt my faith had drifted somewhat. I did not want to interpret the Bible literally like Tom, but I wondered whether I had become too apathetic in my faith and whether this again reflected becoming ‘part of the system’. Perhaps becoming acculturated within the psychology profession

had involved developing a more liberal perspective? By contrast Jesus had been a radical and in some ways I felt that Tom's commitment to his faith seemed closer to Jesus' example than my own faith. Interestingly a tension between radical Christianity and the mental health system was also recognised by a participant in a previous study (Mental Health Foundation, 2002, p. 49) who noted:

*If Jesus turned up today he'd end up in a mental asylum and Mary would be sectioned.*

My concerns about my commitment to my faith returned as I interviewed my participants, several of whom were deeply committed to their faith and whose accounts I found inspiring. Yet, although I was concerned that my faith had drifted, I felt very comfortable with the person I was becoming through training as a psychologist. If I was becoming more liberal in my views, I was glad of it. I was pleased to notice the greater openness and sensitivity I now showed in my work as a therapist and a researcher.

Although the cultures of Christianity and Psychology seemed to clash in some ways, in other ways they seemed entirely compatible. For instance when working as a therapist as a Trainee I have often felt that there is a spiritual aspect to my work. By this I mean that caring for others as a therapist is an expression of my faith and therefore helps me to feel more connected with my faith. Likewise my research interviews felt equally congruent with my faith. This idea of there being spiritual significance in the act of helping others is well established within Christianity, being clearly present in Jesus' parable of the sheep and the goats, in which he advises that whatever Christians do for others, they do for him (Matthew 25:40, *New*

*International Version*). Similarly the idea of spirituality being compatible with the work of psychologists is increasingly established, having risen to prominence in recent years through the use of Buddhist meditation techniques within mindfulness (Kabat-Zinn, 2004).

### **3.4 Staying 'In Role'**

#### ***3.4.1 Friend Not Psychologist***

A further challenge involved in managing my different roles as a Trainee was that of staying 'in role' – staying in the appropriate role for the context and not allowing myself to slip into other roles. I first noticed this challenge when visiting Tom in hospital. The last time I had been on an acute psychiatric ward was several years previously when I had worked as a Nursing Assistant, so my schema (e.g. Stein, 1992) for that environment was one of being a mental health professional. Visiting Tom after work I would arrive on the ward wearing my work clothes and my NHS badge. It was tempting to use my professional role to gain an audience with staff to discuss Tom's care and yet I felt that this was an abuse of power. Although I initially told staff about my role, I soon chose not to. I reasoned that what Tom needed was a friend, not a professional and I should have the humility to renounce my professional status and act as a member of the public – a friend. I felt more at ease with this decision. Interestingly the accounts of my research participants suggest that the simple humanity of friendship may have been the most valuable thing I could have offered Tom. Yet even as I assumed this role I knew that I could never



be only a member of the public; even when acting the role of a friend my other role of psychologist was still part of me and inevitably influenced me. Although I could choose which roles to assume, I could never cease to be affected by my roles.

### ***3.4.2 Researcher Not Therapist***

When interviewing participants for my research I experienced a different challenge to staying in role. This time I was a researcher and the roles to shed were 'Christian' and 'Therapist'. This was my first experience of conducting semi-structured interviews for qualitative research. I was aware that I needed to take a neutral stance in order to help participants to feel comfortable sharing their opinions and experiences without fear of judgement (King & Horrocks, 2010). The first role that I needed to shed was that of therapist. This was challenging; some therapeutic skills were part of both the role of therapist and researcher, whereas other therapeutic skills would jeopardise the quality of the data collected.

Although I remained aware of my role as researcher throughout the interviews, after some interviews I reflected that I had briefly used therapeutic skills such as paraphrasing or had asked questions in a slightly leading way. Given that research interviewing bore several resemblances to therapeutic interviewing it was hard to selectively 'turn-off' some therapeutic skills and not others.

A second challenge of assuming the role of researcher was that of not intervening. To meet a service user with mental health problems and not to offer them an intervention felt disempowering. Without intervening I struggled to believe that I

was helping the participant, who had volunteered to attend the interview without compensation for travel expenses, often despite limited financial resources. In managing these feelings it was important to remind myself that simply meeting an interested listener could be an intervention in itself, serving to validate the participant's experience. This was perhaps particularly true since I would be perceived as a mental health professional who was interested in their spiritual experience, which might contrast with many of their previous experiences with professionals. I also reminded myself that research is an intervention in itself, even if not directly aimed at the participant and this has motivated me to pursue publication of my findings.

#### ***3.4.3 Researcher Not Christian***

The second role to shed when interviewing was that of being a Christian. In doing this the primary challenge was deciding whether to disclose my faith to participants. Any form of self-disclosure would influence my participants' perception of me and could affect what they chose to tell me. However as my participants were also Christians I expected that disclosing my own faith would lead to a deepening of rapport and might potentially elicit richer data. Knowing this I struck a compromise by only disclosing my faith to participants if asked directly by them. In doing so I sought to remain neutral to my participants but also to avoid threatening our nascent rapport by refusing to answer a question about my beliefs.

This approach typically resulted in non-disclosure, which proved more challenging than I anticipated. In my reflective diary entries after several of my interviews I noted feeling like a fraud when not disclosing my faith. There were several reasons for experiencing this feeling. Firstly, non-disclosure involved withholding a part of me that my participants had shared with me. When they had told me so much as a stranger, to not disclose about myself established an uncomfortable power dynamic. I was aware that they had made themselves vulnerable by telling me about very personal experiences and to not respond in kind seemed to communicate superiority, or even seemed slightly voyeuristic. Secondly, non-disclosure felt dishonest. To not tell participants about my faith involved reacting minimally to their experiences of faith and treatment, despite the emotional reactions their descriptions evoked in me. On reflection it is surprising that I found this difficult; suppressing my emotional reactions is often a necessary part of the emotional labour (Hochschild, 1983) involved in my role as therapist. Thirdly non-disclosure felt like a false-disclosure in itself. In presenting only my professional role I worried that participants would assume I didn't share their faith and that I was sceptical of their spiritual experiences. At times the way that participants seemed to defend their faith to me or seemed embarrassed about recounting certain experiences suggested to me that I might be seen as a sceptical atheist. I worried that my questions about the distinction between faith and psychosis might also be perceived as sceptical of faith. I was aware of the vulnerability of some of my participants and did not want to inadvertently challenge their faith, which was a very important support for many of them. On one occasion where I sensed participants wanted to know whether I shared their beliefs I disclosed my faith after

the interview had ended. In response the participant expressed gladness at discovering a mental health professional who shared their beliefs. In other interviews I reassured myself that my curious, open and empathic approach to interviewing would prevent participants from perceiving scepticism. I was also encouraged by the ease with which rapport developed with participants and the richness of the accounts that they gave. Whether or not they believed I was a Christian, participants seemed to trust me and were typically grateful for the opportunity to express their views about a personally relevant subject not often discussed.

#### ***3.4.4 Researcher and Christian***

Staying 'in role' was also a challenge when analysing and writing-up my research. During this process I was aware that I needed not to slip into writing as a Christian rather than a researcher. Yet in conducting Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) it was also appropriate to recognise my position in relation to research – part of which was that of being a Christian. Here my faith was an asset, in that it gave me awareness of the cultural background of my participants. Yet it was also an influence on my interpretations, which I needed to be aware of. My faith provided helpful perspectives on my data but I needed to be able to also take other perspectives and make other interpretations. In doing this it was helpful to discuss my findings with supervisors and other trainees. Through discussion with my supervisors I soon became aware that my faith made me more credulous of my participants' accounts. I recognised the need

to introduce a hermeneutic of suspicion into my analysis (Smith et al., 2009).

However in taking this more sceptical and interpretative stance when writing-up my research I was mindful of how my participants would react to the way I had represented them. Although I had only met them each briefly, I felt that I had come to know them each intimately through in-depth analysis of their interviews and I had a strong protective urge to do them justice. Fortunately I felt very comfortable with the theoretical stance of IPA. In 'making sense of the participant making sense of' the subject matter (Smith et al., 2009) I felt I could represent their experiences in a way that felt respectful to them.

### **3.5 Conclusion**

In accommodating new roles and identities as a psychologist, researcher and therapist I have experienced tensions with existing roles. At times it has felt artificial to act as a Psychologist and I have struggled internally against my new roles. This has been particularly true in managing the tension between my roles as a Christian and a psychologist during this research process. In writing this piece I have focussed on these tensions, but it is not accurate to see these roles as simply being in conflict. In general I have seen my new roles as compatible with my role as a Christian and have felt that my role as a psychologist expresses the whole of me. In fact, just as being a therapist can enrich my work as a researcher, I see my faith and my profession as enriching one another. As I approach qualification I see my faith as informing the kind of psychologist I become and my profession informing the kind of Christian I become.

## References:

- Andersson, T., & Liff, R. (2012). Does patient-centred care mean risk aversion and risk ignoring. *International Journal of Public Sector Management*, 25(4), 260-271. doi: <http://dx.doi.org/10.1108/09513551211244098>
- Bentall, R. P. (2004). *Madness explained : psychosis and human nature*. London: Penguin.
- Boyle, M. (1999). Diagnosis. In C. H. G. D. C. Newnes (Ed.), *This is madness : a critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books.
- British Psychological Society. (2012). DSM-5: The future of psychiatric diagnosis (2012 - final consultation).
- British Psychological Society response to the American Psychiatric Association. Retrieved 1st May, 2014, from [http://apps.bps.org.uk/\\_publicationfiles/consultation-responses/DSM-5 2012 - BPS response.pdf](http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5 2012 - BPS response.pdf)
- Faithless. (2004). I want more - Part 2. On *No Roots*. Sony Music.
- Hochschild, A. R. (1983). *The managed heart : commercialization of human feeling*. Berkeley ; London: University of California Press.
- Kabat-Zinn, J. (2004). *Wherever you go, there you are*. London: Piatkus.
- King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. Los Angeles: SAGE.
- Mental Health Foundation. (2002). Taken Seriously: The Somerset Spirituality Project. London: Mental Health Foundation.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis : theory, method and research*. Los Angeles: SAGE.
- Stein, D. J. (1992). Schemas in the cognitive and clinical sciences: An integrative construct. *Journal of Psychotherapy Integration*, 2(1), 45-63.



# CLINICAL PSYCHOLOGY REVIEW

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INFORMATION PACK**

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## Appendix B: Table Summarising Studies Included in Systematic Review

#	Date	Author(s) and origin	Sample Size	Aims	Method	Findings
1	2011	Allott et al. (Australia)	62 (CBT N=31, befriending N=31)	Investigated predictors of patients' symptom and functional outcomes in ACT/CBT and befriending for First Episode Psychosis (FEP).	Re-analysis of Jackson 2008's RCT of CBT vs. befriending. Examined demographic, cognitive, symptoms/illness and functioning variables in predicting positive/negative symptoms and functional outcome.	Premorbid adjustment predicted positive outcome in befriending group. In CBT group outcome predicted by functioning, avolition and education.
2	2007	Bateman et al. (UK)	Sample 90 patients (46 CBT, 44 befriending) with chronic schizophrenia (positive symptoms resistant to medication)	Investigated whether CBT influences level of suicidal ideation in schizophrenia compared with befriending.	RCT – patients assessed using CPRS rating scale (psychiatric symptoms) at baseline, post intervention and 9 month follow-up.	Reduction in suicidal ideation in both groups. CBT significantly reduces suicidal ideation at end of therapy and sustained at follow-up. Drop in suicidality in befriending group was non-significant
3	2006	Bendall et al. (Australia)	N=40 (21 ACE/CBT; 19 befriending)	To examine whether befriending controlled for non-specific aspects of therapy when compared to CBT in a RCT for acute FEP.	Non-specific factors included time in, expectancy created by, and acceptability of therapy. Expectations and enjoyment of therapy were measured by questionnaire.	Befriending performed similarly to CBT on measures of expectancy, enjoyment of therapy and drop-out rate, but befriending group spent less time in therapy. Concluded that befriending is a credible and acceptable control therapy for FEP.
4	2013	Bendall et al. (Australia)	N=53 (of 62 original Jackson 2008 sample) Young people (15-25) with FEP. (ACE/CBT N=31, befriending N=31). 99 therapy sessions were rated (analysis	To assess therapy contaminations using a new measure and a cognitive therapy scale in a study comparing ACE/CBT with befriending in FEP.	99 recorded therapy sessions were assessed by independent rater.	37% of ACE/CBT sessions contaminated with befriending techniques, 21% of befriending sessions contaminated with ACE/CBT techniques. Befriending sessions all correctly identified. Only 3 ACE/CBT sessions not correctly identified. Despite contaminations sessions were largely identifiable.

## Appendix B: Table Summarising Studies Included in Systematic Review

			was of 50 CBT & 47 BF sessions)			
5	1998	Bradshaw & Haddock (UK)	N=9 (befriending only – no control)	Evaluated effectiveness of an existing befriending scheme for individuals with enduring mental illness	Mixed-methods interview study.	All participants reported that befriending was helpful to them, 67% felt it had improved their confidence in social situations.
6	2001	Davidson et al. (USA)	21 participants drawn from Davidson et al. (2004) sample of 260 people with 'serious mental illness'	Explore participants' experiences of a supported socialization program.	Semi-structured interviews about supported socialization intervention and its impact on community involvement. Analysed using phenomenological / thematic analysis.	Supported socialization produced greater confidence, self-esteem and quality of life. Decreased isolation and loneliness. Participants wanted and were appreciative of opportunities for friendship. Those in control condition expressed regret at not having this opportunity.
7	2004	Davidson et al. (USA)	260 people with 'serious mental illness' 70=Not matched 95=Matched with SU volunteer 95=Matched with non-SU volunteer.	Investigated the role of social support in recovery from serious mental illness.	RCT comparing three conditions. Measures at baseline, 4 months and 9 months. Measured level of symptoms, functional impairment, self-esteem, satisfaction. Analysed using self-report measures and semi-structured interviews.	All groups showed improvement in psychiatric symptoms, global functioning, self-esteem and satisfaction but there were no significant differences between groups. In terms of symptoms and satisfaction participants assigned SU volunteers improved when they did not meet, whereas those assigned non-SU volunteers improved when they did meet with their volunteer. In all conditions depressive symptoms resisted intervention.
8	2009	De Paiva Barretto et al. (Brazil)	21 patients (12 CBT, 9 befriending) with clozapine-resistant schizophrenia.	Compared efficacy of CBT with befriending control group in 21 week trial.	Preliminary control trial comparing outcomes at treatment end and 6 month follow-up on scales of general psychopathology, quality of life and positive and negative symptoms.	CBT more effective than befriending: CBT group showed significant improvement in general psychopathology and positive/negative syndrome scale and improvement in quality of life scale. Improvement in psychopathology stable at 6 month follow-up.

## Appendix B: Table Summarising Studies Included in Systematic Review

9	1999a	Harris et al. (UK)	86 (43 matched clients + 43 controls). Chronically depressed women.	To evaluate the effectiveness of volunteer befriending in producing remission in chronically depressed women, as compared to other treatments co-occurring.	RCT using waiting-list control design. Assessed full or partial remission after 1 year.	Befriending had significant effect on remission rates. Befriending predicted remission when controlled for other treatments.
10	1999b	Harris et al. (UK)	Same as Harris (1999a) for some aspects of analysis. For other analyses sample expanded to 121 clients – (60 befriending, 61 control).	Evaluated role of psychosocial factors affecting success of befriending in producing remission.	Multivariate analysis of the influence of various factors measured at baseline upon outcome of befriending, including stressors and fresh-start experiences.	Standard attachment style and fresh-start experiences enhanced likelihood of remission. Severe stressors and poor coping strategies reduced likelihood of remission. Befriending continued to play a role but not as significant as attachment style, fresh-start experiences and severe stressors.
11	2008	Jackson et al. (Australia)	62 (CBT N=31, befriending N=31) (40% participants had schizophreniform disorder).	Examined whether ACT/CBT or befriending result in reductions in positive/negative symptoms and reduced hospitalisations.	RCT - Up to 20 sessions (max 14 weeks) of CBT/ACT or befriending. Assessed at baseline, mid-treatment, end and 1 year follow-up.	Both groups improved significantly over time. Befriending caught up with ACT/CBT after mid-treatment no sig differences in any outcome measure at follow-up.
12	2008	McCorkle et al. (USA)	N=79 adults receiving Compeer befriending plus TAU. Control N=75 adults received treatment as usual. All had SMI	To evaluate effects of Compeer befriending on wellbeing, social support and psychiatric symptoms.	Quasi-experimental study of existing Compeer befriending service.	Compeer clients reported significant improvements in social support and improving well-being. Active ingredient of friendship takes more than 1 year to develop.
13	2009	McCorkle et al. (USA)	N=20 (12 befrienders, 9 befriendees – one participant was in both groups)	Qualitative interview study of the experiences of befrienders and SUs in Compeer befriending programme.	Semi-structured interviews analysed using grounded theory-style analysis. Also explored whether SU befrienders are better than non-SU befrienders	Compeer befriending evaluated very positively by clients and volunteers. Many friendships developed over several years with deepening friendship bringing greater benefit. SU volunteers were more inspiring, sensitive and proactive in advocating for befriendees.
14	2006	Milne et al. (UK)	2x case study.	Asks what made befriending as effective as CBT in previous	Compared speech content of befriending therapists with	Befriending correlated with social support and significantly different from CBT. Therefore

## Appendix B: Table Summarising Studies Included in Systematic Review

			Studied content of 10 sessions x2	RCT? How does it converge with social support, how does it diverge from CBT?	those of social support workers in psychiatric hospital. Also compared 10 befriending sessions with 10 CBT sessions.	befriending offers a different intervention to CBT – social support.
15	2006	Naeem et al (UK).	CBT N = 47, befriending N=43	To examine effect of CBT on anxiety in patients with schizophrenia. Sub-analyses of two RCTs, one of which compared CBT for schizophrenia with befriending.	Assessment of anxiety symptoms using Brief Scale for Anxiety at baseline, end of therapy and follow-up. ANOVA & t-test analyses.	Anxiety levels of both groups improved at end of intervention. Anxiety levels of Befriending patients relapsed at follow-up. CBT patients maintained reductions in anxiety at follow-up.
16	2007	Samarasekera et al. (UK)	44 patients with schizophrenia. (who formed befriending group in RCT of CBT vs. befriending)	Investigated what variables predicted outcome in befriending.	Regression analysis of change in overall symptoms during intervention and between baseline and 9 month follow-up.	After 9 months baseline delusions predicted a good outcome and baseline auditory hallucinations predicted lack of change following befriending.
17	2000	Sensky et al. (UK)	90 (CBT N=46, befriending N=44)	To compare the efficacy of manualised CBT for schizophrenia with befriending control intervention. Both delivered by nurses	RCT. Assessed at baseline, end of treatment (9 months) and follow-up (9 months later).	Both interventions resulted in significant differences in positive symptoms, negative symptoms and depression at treatment end. 9 months later CBT patients continued to improve, whereas befriending group lost gains.
18	2012	Shawyer et al (Australia)	43 (71% schizophrenia) befriending: N=22 ACE/CBT N=21	Can CBT with ACT strategies reduce negative impact of command hallucinations, as compared to befriending?	RCT. Wait list vs. 15 session CBT/ACT vs. 15 sessions Befriending – & 6 month follow-up.	Both treatments were beneficial and no group differences in main outcomes. Treatments provided different benefits.
19	2000	Turkington & Kingdon (UK)	19 (CBT group N=13, befriending group N=6)	Investigated the use of CBT by psychiatrists for patients with schizophrenia.	RCT comparing befriending with CBT in schizophrenia.	Significant improvements in symptoms in the group treated with CBT but not in befriending group. CBT group had shorter hospital stays in next 6 months.

**Appendix B: Table Summarising Studies Included in Systematic Review**

20	2008	Turkington et al. (UK)	N=59 (CBT=31, BF=28) out of 90 original subjects in previous study in 2000.	Follow-up study of medium term durability (5 years) of effects of CBT & befriending.	Measures of overall symptom severity, neg. symptoms, schizophrenia & Depression administered at baseline, end intervention, 9 month follow-up & 5 year follow-up.	Compared to befriending plus treatment as usual, CBT showed significantly greater & more durable effect on overall symptom severity, level of negative symptoms. No differences between Befriending & CBT on measures of depression or schizophrenia.
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### Appendix C: Table Summarising Befriending Interventions

	Authors & location	Date	Befriending:				
			Was it called 'befriending'? What was the intervention set-up?	Meet in community?	Meet weekly?	Duration?	Training?
1	Allott et al. (Australia)	2011	Yes. Sessions took place in various locations – at home, clinic, neutral location. Paid AU\$20 for 1year follow-up interview for Jackson study. Manualised befriending from a manual of befriending as a control intervention. Focus was on talking. No Matching	Variable – often at home or clinic. If talking was hard then activities including walking could be used.	Up to 20 sessions in 12weeks (>weekly) Actual: mean of 7 total sessions.	3mths (12 weeks) + 1 year F/U.	Yes – in that CPs delivered the interventions
2	Bateman et al. (UK)	2007	Yes. No Matching. Befriending was delivered by psychiatric nurses. Befriending described as non-directive, but involved emotional, informational and practical support (including requesting and providing information, giving advice and helping help with activities). Discussed neutral topics – i.e. not illness.	No. Seen in clinic (but not explicitly stated).	Once/ week for 2mths. Then: Average once every 2 weeks (19 sessions in 9 months)	9mths (average) (F/U at 9mths after end)	Yes – in that trained nurses delivered Befriending
3	Bendall et al. (Australia)	2006	Yes. Manualised befriending from a manual of befriending as a control intervention. Befriending here seen as a directive technique. No Matching.	Unclear, could be either clinic or out in the community.	Goal >1x/week . Actual: mean 7 sessions total.	3 months. & 1year follow-up.	Yes – in that CPs delivered the interventions
4	Bendall et al. (Australia)	2013	Yes. Sessions took place in various locations – at home, clinic, neutral location. Paid AU\$20 for 1year follow-up interview. Manualised befriending from a manual of befriending as a control intervention. Focus was on talking. No Matching	Variable – often at home or clinic. If talking was hard then activities including walking could be used.	Up to 20 sessions in 12weeks (>weekly) Actual: mean of 7 total sessions.	3mths (12 weeks) + 1year F/U.	Yes – in that CPs delivered the interventions
5	Bradshaw & Haddock (UK)	1998	Yes. Matched adult volunteers with people with long term mental illnesses.	Not always. most went out for activities	Variable. 1hour-4hours; daily-monthly Typically weekly.	Ongoing (1-9mths at interview time).	Yes. Volunteers attended training course but no details given.

### Appendix C: Table Summarising Befriending Interventions

				sometimes, some only saw at home		Typically 1-3 months.	
6	Davidson et al. (USA)	2001	No - "Supported Socialisation." Intervention – based on Compeer model (befriending), but difference was that clients & volunteers were matched and then given monthly stipend of \$28/month to fund activities. Paid \$20 to complete interview.	Yes Social/ recreational activities in the community	2-4hrs /week	9 months	Yes – Volunteers had initial orientation & training session + monthly peer-support mtgs.
7	Davidson et al. (USA)	2004	No - "Supported Socialisation." Intervention – based on Compeer model (befriending), but difference was that clients & volunteers were matched and then given monthly stipend of \$28/month to fund activities.	Yes Social/ recreational activities in the community	2-4hrs /week	9 months	Yes – Volunteers had initial orientation & training session + monthly peer-support mtgs.
8	De Paiva Barretto et al. (Brazil)	2009	Yes. Befriending = 'non-specific psychosocial support'. Non-directive sessions – offering sympathy but not using therapeutic techniques. No Matching.	No. Not reported but appears that all sessions occurred in clinic.	~1x/ week - 20 sessions (weekly to every 2weeks at end).	21 week trial (5 months) +6 month follow-up.	Yes – therapists were 2 psychiatrists & 3 CPs. But no training in befriending.
9	Harris et al. (UK)	1999 a	Yes. Matched adult volunteers with adult women with depression. Met, talked to and listened to client, acted as friend.	Not so much – mostly at home but encouraged to go out for trips in community.	1 hour+ / week	1 year - interview at end.	Yes. Volunteers attended several interviews + 3 days training.
10	Harris et al. (UK)	1999 b	Yes. Matched adult volunteers with adult women with depression. Met, talked to and listened to client, acted as friend.	Not so much – mostly at home but encouraged to go out for trips in community.	1 hour+ / week	1 year - interview at end.	Yes. Volunteers attended several interviews + 3 days training.

### Appendix C: Table Summarising Befriending Interventions

11	Jackson et al. (Australia)	2008	Yes. Sessions took place in various locations – at home, clinic, neutral location. Paid AU\$20 for 1year follow-up interview. Manualised befriending from a manual of befriending as a control intervention. Focus was on talking. No Matching	Variable – often at home or clinic. If talking was hard then activities including walking could be used.	Up to 20 sessions in 12weeks (>weekly) Actual: mean of 7 total sessions.	3months (12 weeks) + 1 year F/U.	Yes – in that CPs delivered the interventions
12	McCorkle et al. (USA)	2008	Yes. Matches adult volunteers with adult clients in treatment for SMI. -Adjunct to traditional services. Clients receive ongoing mental health treatment and psychotherapy alongside. -Further details of intervention in other studies referenced.	Yes but can also meet at home. (recreational activities)	Yes - 4hours/ month usually 1hour/ week	12 months+ (often years)	Yes – Volunteers had 2 days thorough.
13	McCorkle et al. (USA)	2009	Yes. Matches adult volunteers with adult clients in treatment for SMI. -Adjunct to traditional services -Clients receive ongoing mental health treatment and psychotherapy alongside. -Further details of intervention in other studies referenced.	Yes but can also meet at home. (recreational activities)	Yes - 4hours/ month usually 1hour/ week	12 months+ (often years)	Yes – Volunteers had 2 days thorough.
14	Milne et al. (UK)	2006	Yes. No Matching. Befriending was delivered by psychiatric nurses. Befriending described as non-directive, but involved emotional, informational and practical support (including requesting and providing information, giving advice and helping help with activities). Discussed neutral topics – i.e. not illness.	No. Seen in clinic (but not explicitly stated).	Once/ week for 2months. Then: Average Once every 2 weeks (19 sessions in 9 months)	9months (average) (F/U at 9 months after end)	Yes – in that trained nurses delivered Befriending
15	Naeem et al. (UK)	2006	Yes. No Matching. Befriending was delivered by psychiatric nurses. Befriending described as non-directive, but involved emotional, informational and practical support (including requesting and providing information, giving advice and helping help with activities). Discussed neutral topics – i.e. not illness.	No. Seen in clinic (but not explicitly stated).	Once/ week for 2months. Then: Average Once every 2 weeks (19 sessions in 9 months)	9months (average) (F/U at 9 months after end)	Yes – in that trained nurses delivered Befriending
16	Samarasekera et al. (UK)	2007	Yes. No Matching. Befriending was delivered by psychiatric nurses. Befriending described as non-directive, but involved emotional,	No. Seen in clinic (but not explicitly stated).	Once/ week for 2months. Then: Average Once	9months (average) (F/U at 9	Yes – in that trained nurses

### Appendix C: Table Summarising Befriending Interventions

			informational and practical support (including requesting and providing information, giving advice and helping help with activities). Discussed neutral topics – i.e. not illness.		every 2 weeks (19 sessions in 9 months)	months after end)	delivered Befriending
17	Sensky et al. (UK)	2000	Yes. No Matching. Befriending was delivered by psychiatric nurses. Befriending described as non-directive, but involved emotional, informational and practical support (including requesting and providing information, giving advice and helping help with activities). Discussed neutral topics – i.e. not illness.	No. Seen in clinic (but not explicitly stated).	Once/ week for 2months. Then: Average Once every 2 weeks (19 sessions in 9 months)	9months (average) (F/U at 9 months after end)	Yes – in that trained nurses delivered Befriending
18	Shawyer et al. (Australia)	2011	Yes. Friendly conversations, like those with a friend on topics of interest and enjoyment. Focus on conversation. No Matching.	No, but could explore neutral activities if conversation is hard.	Goal: 15 weekly sessions. 39 received 12+ sessions.	15weeks (3-4 months)	Yes – clinical staff trained using befriending manual & regular peer supervision.
19	Turkington & Kingdon (UK)	2000	Yes. No Matching. Befriending was delivered by psychiatrist in form of non-directive discussion around neutral topics, such as interests and domestic matters. Didn't talk about treatment.	No. Seen in clinic by psychiatrist at home, hostel, day hospital or inpatient unit.	6 sessions in 2months	2 months (baseline, 1 month, 2month).	Yes – in that Befrienders were trained psychiatrists.
20	Turkington et al. (UK)	2008	Yes. No Matching. Befriending was delivered by psychiatric nurses. Befriending described as non-directive, but involved emotional, informational and practical support (including requesting and providing information, giving advice and help with activities). Discussed neutral topics – i.e. not illness.	No. Seen in clinic (but not explicitly stated).	Once/ week for 2months. Then: Average Once every 2 weeks (19 sessions in 9 months)	9months (average) (F/U at 9 months after end)	Yes – in that trained nurses delivered Befriending

## Appendix D: Quality Framework

#	Questions asked for all studies:		Weight
1	Are the authors credible?		1
2	Is the literature review comprehensive and up-to-date?		2
3	Is the rationale for undertaking the research clearly outlined?		3
4	Is the aim of the research clearly stated?		2
5	Are all ethical issues identified and addressed?		3
6	Is the choice of methodology identified and justified?		4
7	Are all interventions (including control conditions) clearly and sufficiently described?		4
	<b>Quantitative studies:</b>	<b>Qualitative studies:</b>	
8	Is the study design clearly identified? Is the rationale for the choice of design evident?	Are the philosophical background and study design identified and the rationale for choice of design evident?	5
9	Is an experimental hypothesis clearly stated? Are the key variables appropriate and clearly defined?	Are the major concepts identified and appropriate for the participant group?	4
10	Is the population identified?	Is the context of the study outlined?	3
11	Is the sample adequately described and reflective of the population? Was the recruitment strategy justified?	Is the selection of participants described and the sampling method identified? Is the recruitment strategy justified?	5
12	Was study power reported and sufficient? Is the sample size appropriate? Was the intervention duration sufficient to detect change?	Was the choice to stop recruiting justified? Was sufficiency / saturation reported on and reached?	5
13	Have appropriate steps been taken to control for sources of bias (e.g. blinding, method of allocation, attrition)?	Have the researchers critically examined their own role/position and the potential for bias and influence?	5
14	Is the method of data collection, including measures used, valid and reliable?	Is the method of data collection, including any materials used, appropriate and auditable?	4
15	Is the method of data analysis valid and reliable?	Is the method of data analysis credible and confirmable?	4
16	Are results presented in a way that is appropriate and clear?		3
17	Is the discussion comprehensive?		3
18	Are the results generalizable?	Are the results transferable?	3
19	Is the conclusion comprehensive? Are its claims reasonable?		2
	<b>Maximum Total Score:</b>		<b>65</b>

# British Journal of Psychology

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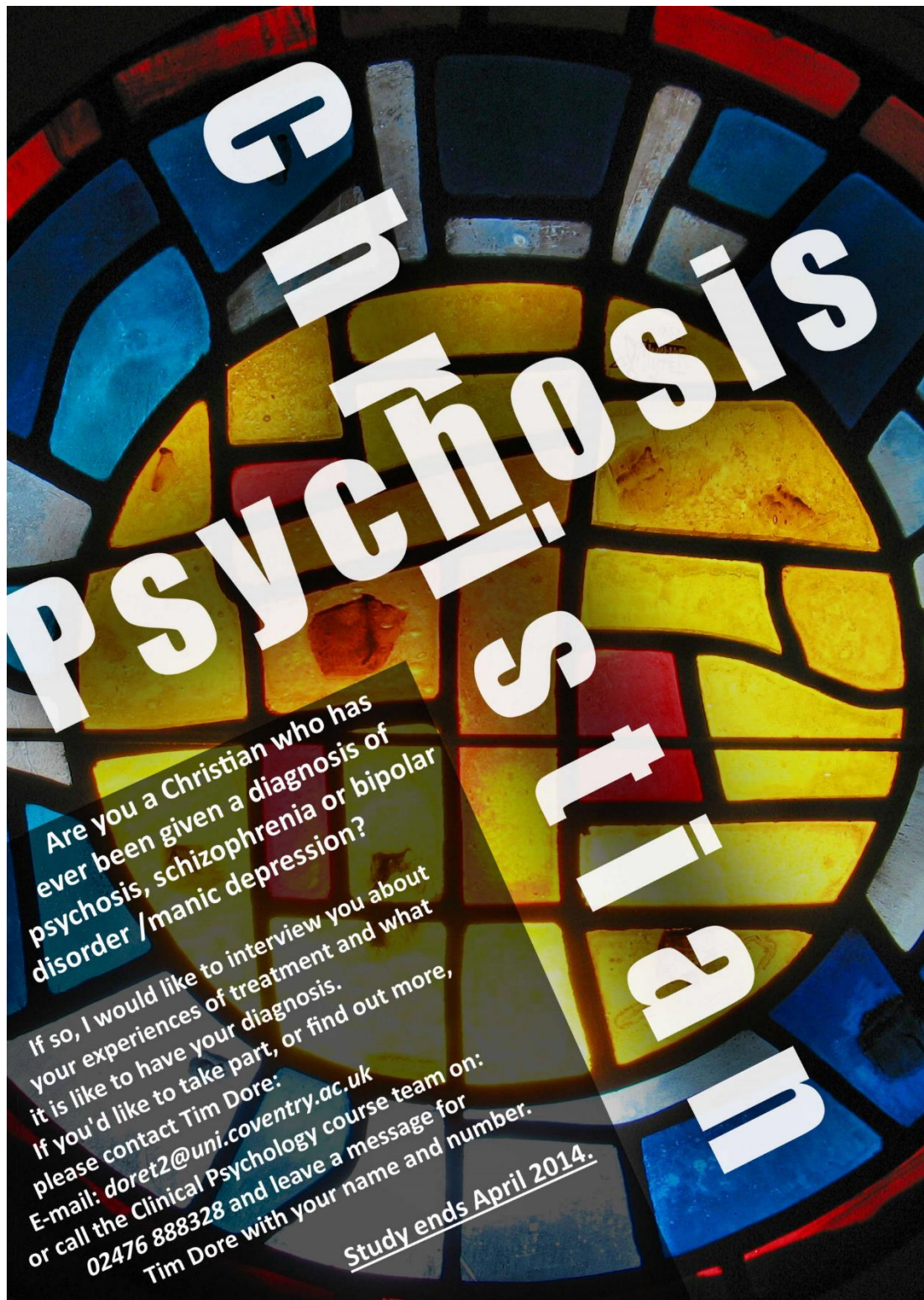
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## Appendix G: Demographics Questionnaire

Demographics sheet version 1.4

[Participant Number: \_\_\_\_\_]

### Some Information About You

Please could you answer the following questions so that we are able to learn more about the experiences of people taking part in this study.

**1) What is your age?**

\_\_\_\_\_

**2) What is your sex?**

☐ Female

☐ Male

☐ Prefer not to say

**3) What is your ethnicity?**

☐ White British

☐ White (other)

☐ Indian

☐ Pakistani

☐ White Irish

☐ Mixed

☐ Black Caribbean

☐ Black African

☐ Chinese

☐ Other Asian (non-Chinese)

☐ Black (others)

☐ Other (please write below):

\_\_\_\_\_

**4) What Christian denomination do you belong to (if any)?**

☐ Anglican / Church of England

☐ Baptist

☐ Catholic

☐ Independent

☐ Methodist

☐ Orthodox

☐ Pentecostal

☐ Presbyterian

☐ United Reformed

☐ Other (please write it below):

\_\_\_\_\_

☐ I don't think of myself as part of a denomination

☐ Prefer not to say

**5) How old were you when you were first treated in a mental health unit / psychiatric hospital?**

\_\_\_\_\_

(Please turn over)

## Appendix G: Demographics Questionnaire

Demographics sheet version 1.4

- 6) How many years has it been since you were last treated for Psychosis? (If currently being treated for Psychosis write '0').

\_\_\_\_\_

- 7) How many periods of mental illness have you had?

- |                            |   |
|----------------------------|---|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4                            |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 - 9                        |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 10 or more                   |
| <input type="checkbox"/> 3 | <input type="checkbox"/> Continuous (since it began). |

- 8) How many times have you stayed in a psychiatric hospital (inpatient admissions)?

- |                            |                                     |
|----------------------------|-------------------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4          |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 - 9      |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 10 or more |
| <input type="checkbox"/> 3 |                                     |

- 9) What mental health problems have you experienced in the past and/or at present? (please tick as many of these as apply to you).

I experienced this problem in the past:

- ☐ Psychosis
- ☐ Schizophrenia
- ☐ Manic Depression
- ☐ Depression
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Eating Disorder
- ☐ Other(s) (please write below)

\_\_\_\_\_

I experience this problem at the moment:

- ☐ Psychosis
- ☐ Schizophrenia
- ☐ Manic Depression
- ☐ Depression
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Eating Disorder
- ☐ Other(s) (please write below)

\_\_\_\_\_

# Participant Information Sheet

## For Research Study: Being a Christian with a Diagnosis of Psychosis

### About the study

Experiencing a mental illness is nearly always a difficult time for us, particularly when this involves staying in hospital, but previous research has found that times of mental illness are also often significant times of growth or crisis in the spiritual journeys of people with a faith or spiritual beliefs.

I am interested in finding out more about the experience of being a Christian who has been given a diagnosis of psychosis, either recently or in the past.

### What is Psychosis?

The mental health charity Mind define psychosis as:

*“experiences, such as hearing or seeing things or holding unusual beliefs, which other people don’t experience or share. For many people, these experiences can be highly distressing and disruptive, interfering with everyday life, conversations, relationships, and finding or keeping a job.”*

### What I want to find out:

I want to explore the following questions:

1. What is it like to be a Christian diagnosed with Psychosis?
2. How do you feel about your diagnosis?
3. What has your treatment for psychosis been like?
4. What spiritual or religious support have you been offered as part of your treatment?
5. Do you think your faith affects your illness (and vice versa)?

### Who is this study for?

I will be interviewing people who meet all of these criteria:

- ☐ You have a Christian faith (whatever Christian group you belong to – includes Catholics, Church of England, Quakers, etc...)
- ☐ You have had a diagnosis of psychosis, recently or in the past, though it may not have been called ‘psychosis’. Here are some terms that may have been used during your treatment if you have had Psychosis:
  - ‘Psychotic’
  - ‘Delusions’
  - ‘Schizophrenia’
  - ‘Manic Depression’
  - ‘Hearing voices’
  - ‘Seeing things’

## Appendix H: Participant Information Sheet

- ☐ You have stayed in a psychiatric hospital (e.g. the Caludon Centre in Coventry) at least once in the past.
- ☐ You are not experiencing severe symptoms of psychosis at the moment.

### **Do I have to take part?**

No you do not have to take part if you do not want to, it is entirely your choice. This is a University study, it is not being run by the NHS, so if you choose not to take part then it will not affect your treatment at all.

### **Can I withdraw from the study?**

Yes, if you change your mind then you can contact me to say that you no longer want to be part of the study. If you change your mind during the interview then I will stop the interview and if you do not want me to use the answers you have already given then I will not use them for the study. If you have already had your interview then as long as you contact me within one month of your interview, you can ask me not to use your interview in the study.

If you decide to withdraw, your recording and any electronic or written information about you will be destroyed and will not be used in the study.

### **What will it involve?**

I will arrange to meet you on two occasions. The first time will be for you to find out what the study involves and for me to find out whether you are suitable for the study. The second meeting will be for a one-hour interview in a quiet and private location that is convenient to you, such as a quiet room in the offices of a charity or in a university building. Before you start your interview you will need to sign forms to say that you understand what the study will involve and that you are happy for your interview recording to be used in the study.

I will use a 'Dictaphone' (sound recorder) to record the interview and a list of questions to ask you. The questions will ask you about your experience of being a Christian with psychosis and your experiences of mental health treatment. I may ask extra questions to find out more about what you have told me. You do not have to answer all of the questions if you do not want to. It is rather like having a conversation but with a prompt sheet. I am interested in your personal views and experiences.

After your interview I will ask you how you have found the interview. If you have found it very upsetting to talk about your experiences then I will talk with you about getting some extra support in order to cope.

### **Are there any risks involved in taking part?**

The only risk in taking part is that you may find it upsetting to talk about the very personal subjects of experiencing mental health problems, receiving psychiatric treatment and what may have been a difficult time in your faith.



**Are there any benefits of taking part?**

- I will be sharing the study results with local healthcare professionals and I hope to publish the findings of this study in an academic journal. By taking part in this study your experiences and opinions will contribute to the results and will be heard by many professionals. We hope this will help to improve mental health services for people with psychosis.
- When the study report is written it is likely that it will quote some of what you have said, but I will make sure that this is anonymous (I will not use your name).
- I expect that most people will find it helpful to talk about their experiences.

**Payment and Travel Expenses**

I am not able to pay you for taking part in this study. If the cost of travelling to an interview for this study is difficult for you to afford, please discuss this with me. I will attempt to find an interview location which is convenient both for you and for me.

**Keeping Your Information Private (Data Protection and Confidentiality).**

I realise that mental health problems and faith are very personal matters. It is very important to me that what you say in your interview is kept anonymous (private). When I create a written version of your interview I will remove your name and use a number to identify who you are. I will use passwords to protect all the information that I have about you. Once the study is completed I will destroy any information that could identify you with your data (such as signed consent forms). I will be the only person who has access to your data during the study.

The only time when I would be unable to keep what you have told me confidential (private) is if you tell me something which makes me very concerned that either you or other people are in danger of harm. If this happened then I would have to discuss what you have told me with either your GP, mental health services or the police.

I will ask you for your permission to use your answers and to quote what you have said in the final report and any articles that we publish about the study. If I quote what you have said I will not use your name and I will remove anything from what you have said that would tell other people who you are. I hope that knowing this will help you to feel comfortable enough to tell me what your experiences of receiving treatment and having a diagnosis of psychosis have really been like.

**What if things go wrong? Who to complain to?**

If I have to cancel an interview then I will try to contact you as soon as possible using the contact details that you have provided for me and I will try to arrange a new time for our interview which is convenient for you.

## **Appendix H: Participant Information Sheet**

If you are unhappy about your experience of taking part in this study please contact me using the e-mail address at the end of this leaflet. Alternatively you may contact one of my supervisors, whose contact details are also below. If you still feel like you would like to make a complaint after you have contacted us then you may wish to contact the Coventry University Ethics team for the Faculty of Health and Life Sciences using this e-mail address: [ethics.hls@coventry.ac.uk](mailto:ethics.hls@coventry.ac.uk)

### **What can I do to help?**

As well as participating, if you know any other Christians with a diagnosis of psychosis then it would be helpful if you could pass on my details to them and an information sheet, so that they can decide whether they would like to contact me and participate in this study.

### **Who has reviewed this study?**

This study has been reviewed by the Coventry University Ethics Committee and by staff from the Coventry and Warwick Universities Clinical Psychology Doctorate course.

### **About the Researcher**

I am a Trainee Clinical Psychologist studying at Coventry and Warwick Universities. This study forms part of my Doctorate Thesis project.

### **Contact Information**

#### Main Researcher:

Tim Dore, Trainee Clinical Psychologist, Coventry and Warwick Universities,  
[doret2@uni.coventry.ac.uk](mailto:doret2@uni.coventry.ac.uk)

#### Supervisors:

Jo Kucharska, Coventry University,  
[jo.kucharska@coventry.ac.uk](mailto:jo.kucharska@coventry.ac.uk)

Adrian Neal, Coventry and Warwickshire Partnership Trust (NHS).  
[adrian.neal@covwarkpt.nhs.uk](mailto:adrian.neal@covwarkpt.nhs.uk)

Deborah Biggerstaff, Warwick University,  
[D.I.biggerstaff@warwick.ac.uk](mailto:D.I.biggerstaff@warwick.ac.uk)



## Appendix I: Informed Consent Form

### Participant informed Consent Form

**Project Title:**

Experiences of Faith, Illness and Psychiatric Treatment for Christians with Psychosis.

**Study Information:**

This study aims to answer the following questions:

1. What is it like to be a Christian with Psychosis?
2. How do you think your faith affects your illness (and vice versa)?
3. What has your treatment for psychosis been like?
4. What spiritual or religious support have you been offered as part of your treatment?

This study will involve an interview of approximately one hour, which will be recorded. Your answers will be compared with the answers given by other participants and a report will be written summarising the results of the interviews. For further information please refer to the **Participant Information Sheet**.

**Instructions:**

Please read each of the statements below and write your initials in the box to show that you agree.

**Please initial**

1. I confirm that I have read and understood the participant information sheet (Version 1.6) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.
3. I understand that all the information I provide will be treated in confidence and that any details which could identify me will be anonymised.
4. I understand that this is a university research project and that it will have no effect on my future healthcare, whether or not I choose to take part in this study.
5. I understand that I also have the right to change my mind about participating in the study for one month after my interview.
6. I agree for my voice to be recorded and for anonymised quotes to be used as part of the research project.
7. I agree for anonymised quotes from my interview to be included in a published report based upon this research project.
8. I agree to take part in the research project


Name of participant: .....

Name of Researcher: .....

Signature of participant: .....

Signature of researcher: .....

Date: .....

## **Participant Debrief Sheet**

### **For Research Study: Being a Christian with a Diagnosis of Psychosis**

#### **Introduction**

Thank you for taking part in my research study. This sheet has been created to let you know what we will do with the recording of your interview and to advise you about what to do if you find that you are feeling worse after speaking about your experiences.

#### **Is there anything more for you to do?**

No, once you have had your interview you do not have to do anything else for my study.

#### **What can you do to help?**

If you know any other Christians with a diagnosis of psychosis then it would be helpful if you could help me to make contact with them so that I can offer them the opportunity to participate in this study.

#### **What happens next?**

Now that your interview has been recorded, I will listen to it again and create a written copy of everything that was said. Once I have collected enough interviews then I will read-through each interview several times and look for similar themes and differences in the answers that the people I interviewed gave me. I will then write a report which will summarises the similarities and differences between the experiences of the people I have interviewed. When I write this report I will use quotes from interviews to give examples of the experiences that people have described to me. It is likely that I will use quotes from you in this report. I will amend any details that could be used to identify you (make them anonymous).

#### **Who will hear about the study?**

I hope to have a report of this study published in an academic journal so that it can be read by many mental health professionals, chaplains and students. In the local area I will share the results of this study with mental health professionals working in the area of psychosis and hopefully also with User Groups and Advocacy groups. I will also create a short summary of the study findings to give to professionals and service users.

#### **Can you have a copy of the study results?**

Yes, if you would like a copy of the study findings then I will send you a summary of the report by e-mail or post once the study report is completed.

#### **Can you still withdraw my interview from the study if I change my mind about taking part?**

Yes, if you change your mind then you can contact me to say that you no longer want to be part of the study as long as you contact me within one month of your interview. If you do this then your interview will not be used in the study. If you feel that you no longer agree with a part of an answer that you give, you may contact me within a week of your interview to request for that answer to be changed.

#### **What to do if you feel worse**

The experiences of having a mental health problem and receiving treatment for mental health problems are both very stressful and distressing for most people. For this reason, talking about these experiences today may have stirred-up some very painful memories. If

## Appendix J: Participant Debrief Sheet

you notice that you are feeling worse after your interview, please tell me about it so that I can talk to you about how you can find help and support.

If you continue to feel worse after this interview and you would like to receive support, you may wish to speak to a healthcare professional, such as your GP or any mental health professionals that you see regularly, such as a CPN or the Crisis team. Alternatively you could contact the Mental Health Matters helpline for support, guidance or information on **0800 616171** (free from landlines), **0300 3305487** (from mobiles) or by text: **07786202242**.

Another service that may be particularly helpful for you is the Samaritans, who offer support over the phone, face-to-face and by e-mail or text. The Samaritans will listen to you and ask helpful questions, but will not tell you what to do. You can call them 24 hours a day. The national number for Samaritans is **08457 90 90 90**. Here are the contact details for the local branch of the Samaritans in Coventry:

*Samaritans Coventry  
57 Moor Street  
Earlsdon  
Coventry, CV5 6ER*

*Telephone: 02476678678 (Coventry).*

*E-mail: [jo@samaritans.org](mailto:jo@samaritans.org)*

*Website: [www.samaritans.org](http://www.samaritans.org)*

*(Usual hours open to receive callers at the door: 10:00am - 9:00pm).*

### **What if you have had a bad experience - Who to complain to?**

If you are unhappy about your experience of taking part in this study please contact me using the e-mail address at the end of this leaflet. Alternatively you may contact one of my supervisors, whose contact details are also below. If you still feel like you would like to make a complaint after you have contacted us then you may wish to contact the Coventry University Ethics team for the Faculty of Health and Life Sciences using this e-mail address: [ethics.hls@coventry.ac.uk](mailto:ethics.hls@coventry.ac.uk)

### **Contact Information**

#### Main Researcher:

Tim Dore, Trainee Clinical Psychologist, Coventry and Warwick Universities,  
[doret2@uni.coventry.ac.uk](mailto:doret2@uni.coventry.ac.uk)

#### Supervisors:

Jo Kucharska, Coventry University,  
[jo.kucharska@coventry.ac.uk](mailto:jo.kucharska@coventry.ac.uk)

Adrian Neal, Coventry and Warwickshire Partnership Trust (NHS).  
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Deborah Biggerstaff, Warwick University,  
[D.I.biggerstaff@warwick.ac.uk](mailto:D.I.biggerstaff@warwick.ac.uk)

## Interview Schedule

### Pre-Interview Checklist:

- ☐ Who I am and Thank you for agreeing to take part.
  - ☐ Brief reminder of study focus and aims
  - ☐ Give demographics form to complete (if not already done).
  - ☐ Check – have they read and understood participant information sheet?
  - ☐ Signed participant consent form?
  - ☐ Reminder that the interview will be recorded and may be used in a published report, but their answers will be kept anonymous.
  - ☐ Reminder that they don't have to answer each question and can withdraw at any point, which will not affect their treatment.
  - ☐ Explain – I have a list of questions which are just there to remind me. I may take a few brief notes as we go along – is that Ok?
  - ☐ Any questions to ask about the study before we begin?
- 

(If unclear, use reminder of Mind's definition of psychosis):

***"Experiences, such as hearing or seeing things or holding unusual beliefs, which other people don't experience or share. For many people, these experiences can be highly distressing and disruptive, interfering with everyday life, conversations, relationships, and finding or keeping a job."***

<start recording>

### Getting to know you

I've got a few questions here , some of which I'll ask you later on, but most of all I'm interested to get to know you and understand a bit about what your life has been like. That way I'll understand where you're coming from.

1. So to start off with I wonder whether you could tell me a bit about yourself?

- [Prompt] And what has life been like for you up to now?

## **Appendix K: Interview Schedule**

2. May I ask what made you decide to volunteer to talk to me?

- Was there anything that you had in mind to tell me about today?

### **Attitude towards own diagnosis**

3. Thinking of when you received your diagnosis, can you tell me a bit about that experience?

4. When did you first hear anyone talk to you about your diagnosis?

5. What happened? Can you describe it to me?

6. How did it make you feel?

7. Had anyone mentioned the term 'psychosis' to you before?

- [Prompt] How did you feel about your diagnosis at the time?
- >>[Probe - If in the past] How about now?
- >>[Probe] How did your family or loved ones respond to your diagnosis?
- >>[Probe] How do they respond to your diagnosis now?

### **Experiences of mental health treatment**

8. How would you describe your experience of the treatment you received for your illness?

- [Prompt] What was your treatment like, as a patient diagnosed with psychosis? (For example if you stayed in a clinic or a mental health unit, or when you went for appointments?)

## **Appendix K: Interview Schedule**

- >> [Probe] Can you remember any good experiences you had there?
- >> [Probe – if yes] Can you tell me about them? - About a good experience you have had during your treatment?
- >> [Probe] Can you tell me about any bad experiences you may have had during your treatment?
- >> [Probe – if in past] What has it been like since your treatment? (What have your experiences been like?)

### **9. Have you attended any other services outside the NHS when experiencing psychosis / during your illness?**

- [prompt – if yes] What was your experience of these services?

## **Experiences of treatment as a Christian**

### **10. What are your thoughts about talking to professionals about your faith and beliefs?**

- [Prompt] for example, have you ever spoken to religious professionals in the health service, such as a hospital Chaplain, about your faith?
- [Prompt] Have you ever spoken to mental health professionals such as nurses, psychiatrists or psychologists about your faith?
  - >>[Probe – if yes]. How did that person / member of staff respond to you speaking about your faith?
    - >>[Probe – if yes] Have you spoken to any others? How did they respond?
  - >> [Probe – if no]. Were there any reasons that you chose not to speak to staff about your faith?

### **11. In your experience, have mental health professionals asked you about your faith or spiritual beliefs?**

## **Appendix K: Interview Schedule**

- [prompt - if yes] What has been your experience of them asking you about your faith
- [prompt – if no] Do you have any thoughts about whether Mental Health professionals should ask patients about their faith or beliefs?

### **12. Have you spoken to people at church about your experiences of psychosis or other mental health problems?**

- [prompt – if yes] What has been your experience of talking to them about your faith?
- [Prompt – if no] Did you choose not to speak to people at church about your illness?
  - i. [probe – if yes] were there any reasons that you chose not to speak to people at church about your illness?

**Next I'd like to move on to talk about your understanding of faith and mental illness.**

## **Distinction / confusion of faith and psychosis**

### **13. What are your thoughts about whether professionals see your Christian faith similarly or differently to the way they see symptoms of psychosis?**

### **14. Have you ever felt that your faith experiences were seen by professionals caring for you as being symptoms of psychosis / due to your illness?**

- >>[Probe] Could you tell me more about this experience?
- >>[Probe] How did you feel about this experience at the time?
- >>[Probe] How do you feel about it now?

15. Do you think you have ever confused part of your illness / a psychotic experience with a faith experience?

- [prompt] Can you tell me a little bit about what happened?
- >> [probe] In your view, can the kind of experiences you describe of illness / psychosis also be spiritual experiences?
- >> [probe] Do you think it's possible to tell the difference between experiences of faith and psychosis?

### **Being a Christian with Psychosis**

16. What is it like being a Christian diagnosed with psychosis?

- [Prompt] Do you think that having psychosis is different for Christians, than for other people?
- >>[Probe] Are there any ways in which it is easier to cope with your diagnosis (i.e. psychosis) as a Christian?
- >>[Probe] Are there any ways in which it is more difficult for you to cope with your diagnosis (i.e. psychosis) as a Christian?

17. Do you know any other Christians who have been given a diagnosis of psychosis?

- >>[If yes – Probe] Can you tell me a little bit about what it was/is like for them to be a Christian diagnosed with psychosis?
- >> [If yes - Probe] Do you know anything about what their experience of treatment has been like?
- >> [If yes – Probe] Have they ever felt that professionals saw their faith experiences as symptoms of psychosis?

### **Suggestions and Further Comments**



## **Appendix K: Interview Schedule**

18. What are your thoughts about whether mental health services could be improved for Christians with Psychosis?

- [Probe] Do you have any ideas or suggestions about what changes could be made?

19. Is there anything that you would like to tell me before we finish?

<stop recording>

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### **Debrief**

Thank you for taking the time to be part of this study. Your experiences, opinions and ideas are really valuable in helping me to better understand this topic.

- How do you feel after answering these questions?
- Are you feeling upset or unhappy about anything that we have talked about?

## Appendix L: Evidence of Ethical Approval

### REGISTRY RESEARCH UNIT ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

**Name of applicant:** Timothy Dore .....

**Faculty/School/Department:** [Faculty of Health and Life Sciences] Clinical Psychology

**Research project title:** Experiences of Faith, Illness and Psychiatric Treatment for Christians Diagnosed with Psychosis

Comments by the reviewer

#### 1. Evaluation of the ethics of the proposal:

The ethics of the proposal are mostly sound.

The applicant should provide some brief commentary on how much experience they have working with the proposed participant group. If the applicant is familiar with supporting individuals diagnosed with psychosis, the interviews do not necessarily need to be facilitated/observed by a trained professional (e.g., research supervisor or Rethink/MIND employee). If however, the applicant is inexperienced, an appropriately experienced facilitator/observer would be recommended.

Section 12 point 9 requires clarification. The applicant has indicated that participants will not be in a position whereby they will not feel empowered to refuse to participate in the research. However, commentary is provided that suggests that this may be the case but that procedures to limit this have been put in place. The applicant should change point 9 to 'yes' if this is the case.

#### 2. Evaluation of the participant information sheet and consent form:

The content of the PIS is suitable to the aims and purpose of the study. I would consider removing the first page that includes the quotes as this is not needed and some of the quotes may be taken out of context.

The consent form should include a statement to clarify that participation in the study will not affect the participant's access to or quality of routine healthcare (or words to that effect). This will help to clarify the problem identified with section 12 point 9 above. Also check the formatting of the form before use as the top half the logos were missing when this was reviewed.

In addition to the Samaritans, the debrief form should also include some reference to participants accessing their usual source of support (e.g., CPN, GP, Criss Team).

The interview guide seems appropriate in terms of meeting the aims of the study. This is more of a methods issue than an ethical consideration but consider opening up some of the closed questions you intend to ask.

#### 3. Recommendation:

(Please indicate as appropriate and advise on any conditions. If there are any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

<input type="checkbox"/>	Approved - no conditions attached
<input checked="" type="checkbox"/>	Approved with minor conditions (no need to re-submit)
<input type="checkbox"/>	Conditional upon the following – please use additional sheets if necessary (please re-submit application)

## Appendix L: Evidence of Ethical Approval

Experiences of Faith, Illness and Psychiatric Treatment for Christians Diagnosed with Psychosis

P9236

	Rejected for the following reason(s) – please use other side if necessary
	Not required

**Name of reviewer:** Anonymous.....

**Date:** 16/05/2013.....

## Appendix L: Evidence of Ethical Approval

### Researcher's Response to Ethical Review:

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**Addressee:** Coventry University Ethics Committee – Health and Life Sciences (HLS).

**Regarding:** P9236 - Experiences of Faith, Illness and Psychiatric Treatment for Christians Diagnosed with Psychosis.

**Researcher:** Tim Dore, Trainee Clinical Psychologist

Thank you for reviewing my ethics proposal and for granting it approval with minor modifications. I have discussed your feedback with my supervisors and will address your comments below. I am submitting this response, together with the related documents, both to you and to my supervisors.

### Response to Ethics Feedback

#### 1) Experience of working with individuals with psychosis

I have worked with individuals with psychosis on several occasions and performing different roles. Initially I worked voluntarily for a year as a befriender to a man with schizophrenia, I then worked for six months as a nursing assistant on psychiatric wards, in which a large proportion of patients had previously or were currently experiencing psychosis. I later worked voluntarily for several months with homeless and vulnerable individuals, many of whom had multiple complex needs including substance misuse problems and mental health problems such as psychosis.

As a Trainee Clinical Psychologist I am undertaking a series of six month placements working therapeutically with clients in a range of clinical settings. This has given me further experience of working directly with individuals experiencing a wide range of psychiatric problems. Through this experience I have worked with individuals with very challenging behaviours. In this role and my previous clinical roles I have managed stress and have worked independently, whilst also making appropriate use of supervision. I am attaching a brief summary of the current and previous roles I have performed in which I have worked with individuals who have severe and enduring mental health problems such as psychosis.

I have discussed these experiences with my supervisors, who are satisfied that I am sufficiently experienced in working with the client group in question to conduct interviews independently.

#### 2) Section 12 point 9

As advised this point has been changed from 'no' to 'yes'. As I am unable to modify the online version of the ethics form now that it has been submitted and approved I have made this change to a copy of the ethics form in a Microsoft Word document.

#### 3) Informed consent form

The wording has been amended as requested to include an additional statement, acknowledging that participation in the study will not affect future treatment. The university logos have also been checked as advised.

## **Appendix L: Evidence of Ethical Approval**

### 4) Participant Debrief Sheet

The wording of the debrief sheet has been modified to include reference to participants contacting healthcare professionals with whom they would usually have contact, such as GP, CPN etc.

### 5) Interview Schedule

In discussion with supervisors it was agreed that the wording of the interview schedule questions would benefit from being less closed. The schedule will be revised accordingly.

# Appendix M: Coded Transcript Extract

<p>not knowing - unaware</p> <p>brilliant treatment vs bad treatment</p> <p>being given information real vs not real</p> <p>mad vs - understandable explainable</p> <p>Others explained</p> <p>loss of language</p> <p>explanation of illness finding meaning</p> <p>being told vs not being told</p> <p>information withheld</p> <p>not my usual doctor not knowing diagnosis length of relationship</p> <p>hearing second hand</p>	<p>1 PP: Uh, d'you know, I had it and I didn't know, um, I I didn't know I had</p> <p>2 it, I didn't know it was called that and I'd I think I really only found that</p> <p>3 out when I was at &lt;inaudible&gt; day unit and that was &lt;name of unit&gt; in</p> <p>4 &lt;city&gt; - &lt;name of unit&gt; day hospital.</p> <p>5</p> <p>6</p> <p>8 TD: yeah, yeah, how long ago was that?</p> <p>9</p> <p>10 PP: Right, that was, we're going back six years, and that's where I then, I</p> <p>11 believe got brilliant treatment for the first time ever - um they explained</p> <p>12 what was going on in me mind, what was real, what wasn't real - they</p> <p>13 started to give names to things - and I was, I was absolutely amazed - I</p> <p>14 just thought I was mad, y'know, but they, although I had a a grasp of the</p> <p>15 bipolar, I thought I knew all about it - it was only till I was at &lt;name of</p> <p>16 centre&gt; that I realised that I didn't, um they started to tell me, 'cos I, I I'd</p> <p>17 I'd become a, they call it a, like a, uh, uh, uh, um a vegetated state, more</p> <p>18 um I mean I couldn't talk things like that, I couldn't find words I would</p> <p>19 have to point at things - in my mind I kept trying to say about things "you</p> <p>20 don't see what I'm seeing and you don't hear and you don't feel and"</p> <p>21 um, and then they started to use words like psychosis, and they started</p> <p>22 to tell me - I I didn't know about being manic... and I wasn't told all the</p> <p>23 words, I wasn't really told much about me illness, I remembered the - I</p> <p>24 remember the psychiatrist at - the consultant that diagnosed me and his</p> <p>25 doctor psychiatrist said "you've got a bit of this, a bit of that and a bit of</p> <p>26 the other" and he didn't mention bipolar, it was um, it was a couple of</p> <p>27 years later when I went and seen a different GP and I love my GP - I've</p> <p>28 stayed with him for hmm - I've stayed with him for 21 years, um and and</p> <p>29 I was crying and the next minute I'd be quite elite and then down and he</p> <p>30 says "well it's your bipolar" and I says "what's that?" and he says "that's</p> <p>31 what you've got" and I says "I've got depression" and he says "well that's</p> <p>32 what you were diagnosed with bipolar" and that was the first I heard</p> <p>33 about it - the title.</p> <p>34</p>	<p>information withheld</p> <p>established relationship</p> <p>information withheld</p>
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## Appendix M: Coded Transcript Extract

	1	TD: How long ago was that?	
	2		
	3	PP: Um, I was diagnosed with bipolar – it has to be sixteen years now	
	4		
	5	TD: and this, this conversation with the GP	
	6		
not my doctor	8	PP: This conversation with the GP was five to six years later, right, um	not my usual doctor
	9	now it wasn't my own GP, it was head of practice seen - my own GP was	
diagnosis as shared	10	off, um and when he came back from holiday my own GP – I raised it	
	11	with him, 'cos I was quite shocked – I didn't know I had bipolar, so I	established relationship
	12	didn't, and I raised it with him and he says "<name>, I didn't know you	
good GP = length of relationship	13	didn't know you had it" he says – because he's a really good GP and I'm	
	14	still with him, um, I can tell him anything – he's seen me manic, he's seen	
	15	me out of it, um, he says that, "in your notes it says that you were	
	16	diagnosed and who diagnosed you and when" he says "but you would	
	17	never mention bipolar so I went along with you when you called it	
	18	depression", he says, "so I went along with what you were happy to talk	
	19	about", he says, "I didn't know that you weren't told", um, but he was	
knowledge as power understanding illness	20	absolutely, a- and then it was like "God I've got something I can look it	
	21	up" um and then pieces started to come together and then, um, I was	
depression	22	referred to the <name of unit> day unit and my partner had had enough	
	23	– I went down into a very low spell, a very very down bad, bad low	
	24	moods, very suicidal, sleeping for 20 hours a day 18 to 20, when I was up	
strain on others	25	it was to eat and go to the toilet, watch the clock to go to bed and in the	
	26	end he says "you have to go - I can't take it any more" and I was barely	
	27	talking I couldn't talk and things like that – um – they rang me consultant	
	28	who sent out the crisis team and they came out and they were shocked	
crisis team	29	at what they found – they couldn't believe I was allowed to get into a	
tuning point	30	state like that and it was them as that referred me to <name of unit> six	
	31	– just over six years ago and that's when everything started to change.	
	32		
	33	TD: Yeah, yeah, Ok – and your treatment's been better since, since then?	
	34		

## Appendix M: Coded Transcript Extract

<p>verbal - spelling</p> <p>Feeling understood</p> <p>pro understanding me</p> <p>anger</p> <p>medication makes it worse</p> <p>treatment = needs</p> <p>hang words</p> <p>having explanations</p> <p>accepting others</p> <p>CBT</p> <p>openness of pros to faith</p> <p>faith as problem</p> <p>not talking about faith</p> <p>faith seen as illness</p> <p>faith ≠ illness</p>	<p>1 PP: I'm very verbal now with me treatment, I'm not like bang: my</p> <p>2 psychiatrist, um my, my CPN understands me very well and and um, I</p> <p>3 never ever see my consultant, I always see the doctors under him –</p> <p>4 never see him at all – don't like him anyway – um he was the that one</p> <p>5 before had me doped-up on medication that I ended up putting on all</p> <p>6 the weight and becoming a vegetable. Every time I went it was just more</p> <p>7 medication, um, when I went to &lt;name of unit&gt; when they taught me</p> <p>8 CBT when, when they told me the names of different – their doctor told</p> <p>9 me I'd went into hibernation – well I didn't know there was a word for it</p> <p>10 – they-they were telling me words that matched the conditions! Um,</p> <p>11 and also loss of memories, um, and they explained to me simply that...</p> <p>12 you're like using a computer if you print something delete and get rid of</p> <p>13 it, it's gone – then it was gone – now you can get it back! Nowadays, but</p> <p>14 they says that's what's happened, stop trying, y-you know, stop trying,</p> <p>15 you're saying you're not well yet your memories aren't bad – if they</p> <p>16 come back they come, if they don't they don't, you know, so and and it</p> <p>17 was them then that used the CBT all the time and taught me how to use</p> <p>18 it, um and that's where the difference was in the six years and also it was</p> <p>19 them that the nurses now, I'm not saying the professor that was looking</p> <p>20 after me, but the nurses didn't have a problem with my spirituality and</p> <p>21 then they seen my Christianity – they understood my belief, um and that</p> <p>22 wasn't a problem for the first time, but it always had been a problem</p> <p>23 before.</p> <p>24</p> <p>25</p> <p>26 TD: So I wanted to talk about that as- it's good that you brought that up,</p> <p>27 um. Ok, so... um, yeah, wha- what has it been like to talk a- talk with</p> <p>28 professionals about your faith?</p> <p>29</p> <p>30 PP: I- I very rarely mention it – I keep tight lipped, um they, first of all</p> <p>31 they think it's part of me condition, right – which is wrong – I believe it's</p> <p>32 wrong. Um, we were brought up to be Christians at home – just like all</p> <p>33 the other families, you know – they all didn't turn out bipolar! Y-y'know,</p> <p>34 Um... I was brought up in the church, and I was brought up to be as a</p>	<p>ineffective treatment</p> <p>openness of pros to faith</p> <p>not talking to pros about faith</p> <p>faith seen as illness</p> <p>faith separate from illness</p>
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## Appendix M: Coded Transcript Extract

good Christian	1	good a Christian as you could be, and that's how we were all brought up	
God on watching	2	and you went to Sunday school – y'know, God's watching you, don't do	
love for God	3	naughty things and whatever, and if you do ask for forgiveness, but I	
spiritual feeling	4	always had um, I always had a great love for God – inside - and I call it	
over-diagnosis.	5	that spiritual feeling, you know, um... be- talking to psychiatrists 'n that I	
	6	quickly realised that they were um diagnosing me with other conditions	
	7	because of what I was saying and then I realised that the best thing to do	
	8	is not to talk about it, um, because then I realised that I, I hadn't realised	
psychiatrists' interpretations	9	that how they perceive what you're saying and how they interpretate it	
psychiatric notes	10	and how they write it in your notes.	
power of psychiatrists	11		
	12		
	13	TD: Can you remember any examples of that?	
	14		
mistaking my psychosis	15	PP: Ah... well I'd I'd mentioned uh um I suffer from psychosis and	
as faith	16	paranoia, um, and uh yes there – there were times when that was what	
not knowing psychosis	17	it was but because I didn't know and was never told, right, I couldn't	
spirituality different	18	understand "actually, yes, that was. However, when it comes to	
from others	19	spirituality and my religion – that's not." However, to them-	
	20		
	21	TD: it's all together	
	22		
	23	PP: it's all together	
	24		
	25	TD: mmm	
	26		
Belief in God	27	PP: um and for me to believe that there -well they don't have a problem	
as normal	28	with you believing in God, they have a problem if you're coming away	
unusual beliefs =	29	from Christianity in the Bible and you have other beliefs, right, because,	
problem	30	they understand that people will read the Bible and it's their religion that	
pres. understand	31	they've been brought up into, um, but for somebody like me that	
Christianity	32	believes that spirits can communicate with us from the other side – um,	
non-standard Christian	33	an- and I don't mean just dead people, you know, uh I mean sometimes	
beliefs	34	I've felt Jesus and God, um and felt the feeling come through me to be	
communicating with			
spirit			

faith seen as others

[choosing not to tell people about faith]

faith blurs into others

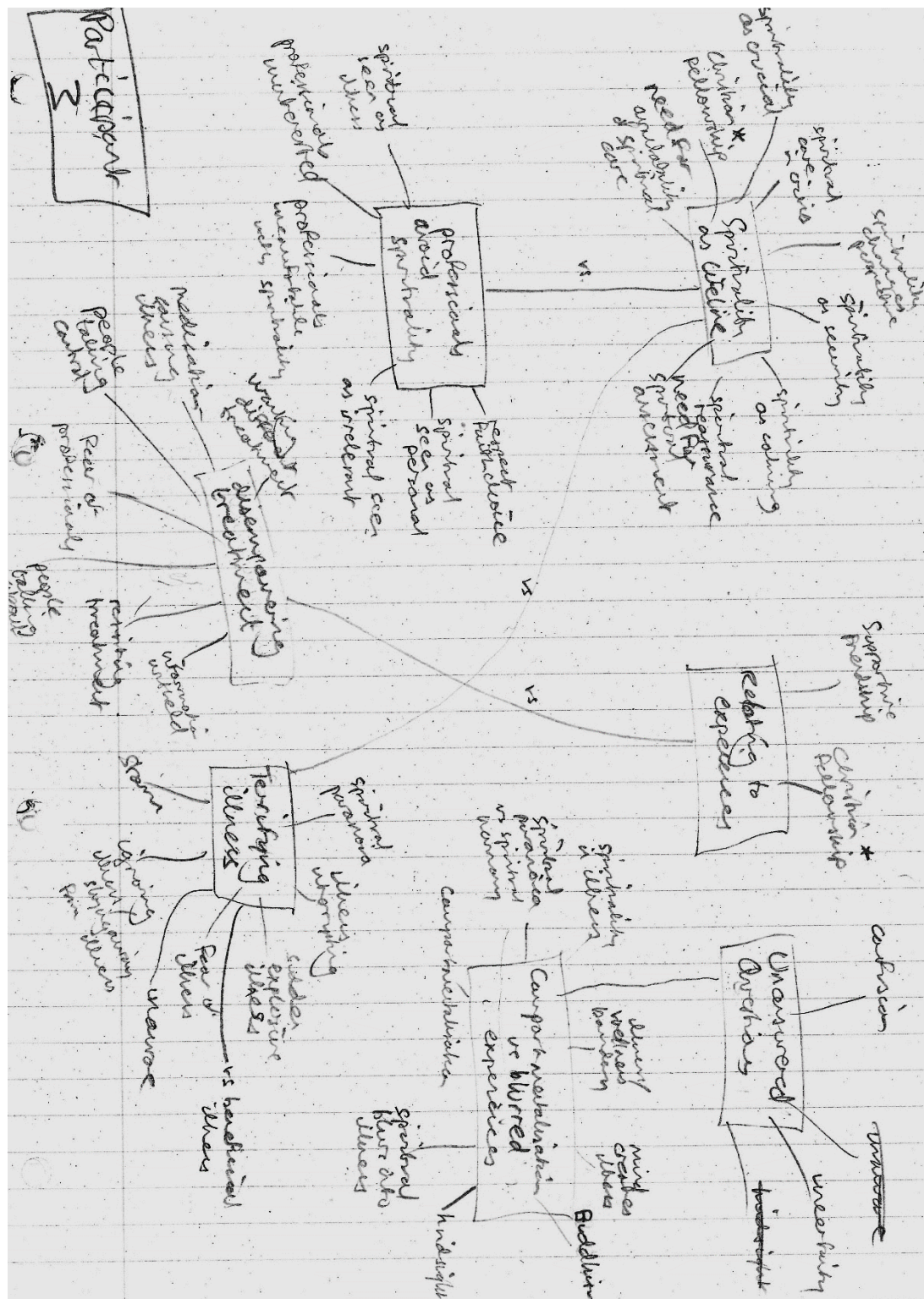
faith separate from others

faith seen as others

faith seen as others

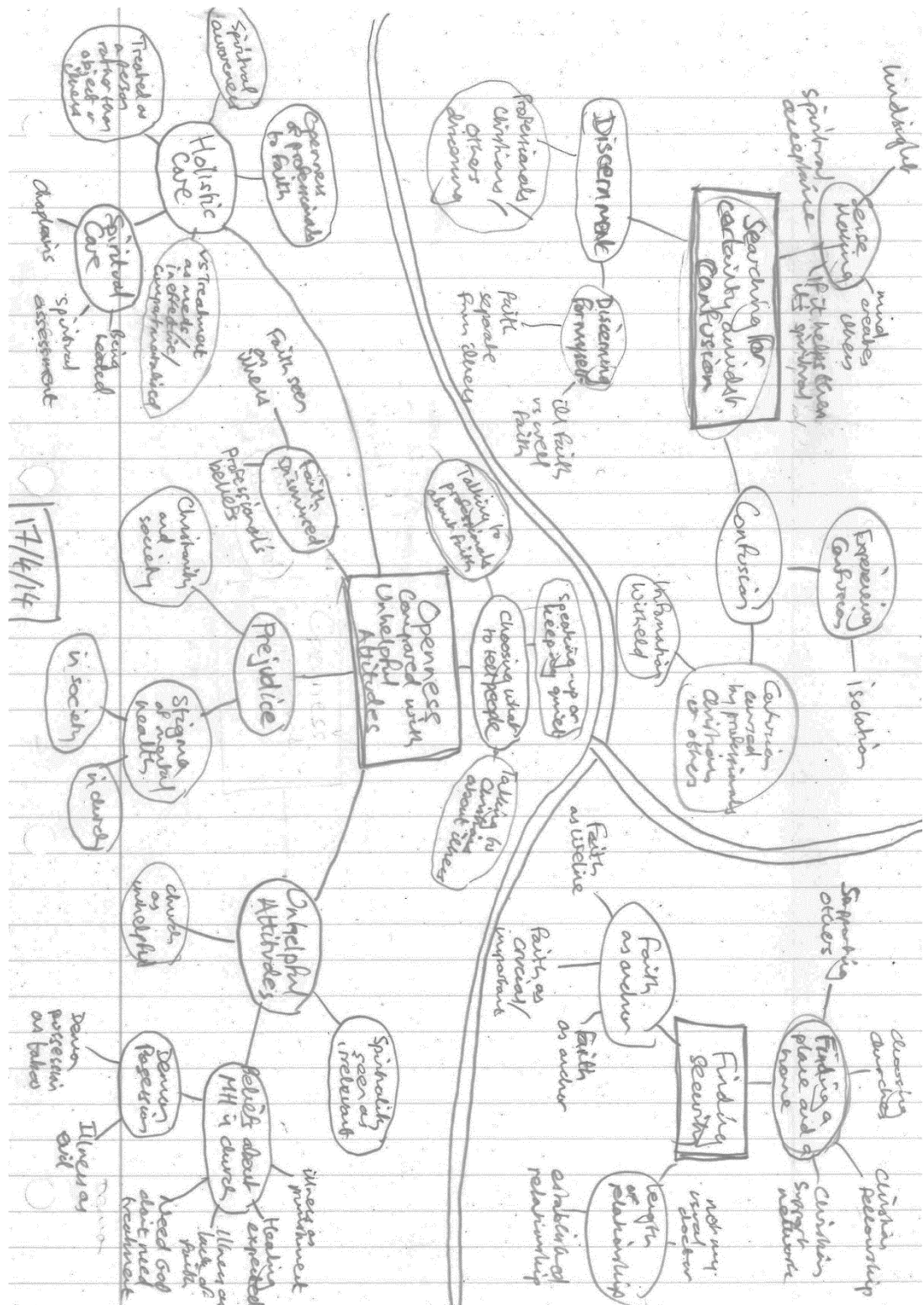
## Appendix N: Examples of Thematic Maps

Thematic map of emergent themes for one participant's transcript:



## Appendix N: Examples of Thematic Maps

Thematic map synthesising emergent themes for all participants. This was created late in the analysis process during the iterative revisions of the thematic structure prior to writing-up the analysis.



## **Appendix O: Extracts from Reflective Journal**

Extracts from the reflective journal kept during the research process are presented below. In the interests of confidentiality these quotations have been anonymised.

### Meeting at a mental health charity to promote the study to service users:

"The service users at [the charity offices] were certainly a different category of participant to those I have interviewed so far. Whereas my participants have all been middle-class and been fairly stable, these service users seemed a lot less well. I was in a drop-in environment and the service users seemed more like people who would be seen on an acute psychiatric ward. My impression was of people on anti-psychotic medication whose lives had fallen apart more, or more recently... I immediately felt less at ease, less comfortable, less welcome. I was aware that I was wearing my work gear, so immediately I will have reminded them of authority figures – perhaps Psychiatrists – and put them on guard – activated a defensiveness, perhaps.

I realised that I need to beware of judging whether someone is appropriate on the basis of whether they are similar or different to my other participants. I need not to confuse non-middle class [individuals with psychosis] with [being] non-appropriate – people may struggle to express themselves as eloquently but still be well enough... then again the sense I got that these people were less likely to be appropriate may have been correct."

### Interview A:

"interesting to be a person doing research and hearing about faith experiences whilst in 'work mode'. Did I have more of a scientific mind today? I perhaps felt a bit more disconnected with her references to scripture than I would normally do in a church setting."

"I was always trying to avoid being leading and I tried only to reflect back what she had already said to me. ...I felt at some points my reflections slightly created distance between us."

### Interview B:

"Being neutral was harder this time – perhaps because I felt more in agreement with this participant – they held more similar views to me. I found it hard at first not to mention that I had [had] similar experiences to them"

### Interview C:

"We covered a great deal in the time and I felt actually that we didn't go into great depth with any of it. Perhaps I was feeling that she wasn't completely emotionally present – there weren't any instances of strong emotion in the room, but on the other hand we did explore some experiences quite thoroughly and achieved good coverage."

### Interview D:

"Being asked 'how old are you?' first of all was amusing, this was followed-up with 'are you a Christian yourself' and 'where do you go to church?' It was important for

## **Appendix O: Extracts from Reflective Journal**

[the participant] that I was a Christian as well as training as a Psychologist. I wondered as she asked me these things whether to disclose my faith – was that being non-neutral? ‘Colluding’? That seems a rather strong word to use for it, but it felt perhaps like stepping away from impartiality... Certainly in this case it helped trust and rapport [to disclose].”

“It is hard to withhold all opinion in a situation in which you are discussing something you’re really interested in.”

### Interview E:

“Another tricky situation was [the participant] saying (about an incident of bad practice) ‘I mean what do you think about that?’ – putting me on the spot to condemn another clinician – again I was acutely aware of not wanting to be anything but neutral, but feeling that it was rejecting of my participant not to agree – and my real feeling was that I wanted to agree with him. In past interviews I have expressed surprise at bad practice but not explicitly condemned – this felt like a valid compromise.”